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THE UNIVERSITY OF ALBERTA

PERSONALITY STYLES AND COPING STRATEGIES OF ALCOHOLIC MEN

by

LYNDA MAY GRIFFITHS

(C)

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

AND RESEARCH

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF

DOCTOR OF PHILOSOPHY

IN

COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

SPRING, 1989

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "PERSONALITY STYLES AND COPING STRATEGIES OF ALCOHOLIC MEN" submitted by LYNDA MAY GRIFFITHS in partial fulfillment for the degree of DOCTOR OF PHILOSOPHY IN COUNSELLING PSYCHOLOGY.

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Abstract

The coping strategies and personality patterns of 35 inpatient male alcoholics as revealed by the Millon Clinical Multiaxial Inventory (MCMI) and the Ways of Coping Checklist (WCCL) (Lazarus & Folkman, 1984) were investigated. In addition, the Millon Behavioral Health Inventory (MBHI) was also used to assess basic coping styles as they related to appraised coping strategies in the sample of male alcoholics. Selected prototypes, previously identified in the literature by Bartsch and Hoffman (1985) and by Nervanio and Gross (1983) were correlated with appraised coping strategies. The results indicate that personality dimensions of both the MCMI and the MBHI are related to appraised coping strategies of the alcoholic males. Prototypes also revealed minor relationships with coping strategies. In addition, the WCCL measured coping strategies amongst 35 non-alcoholic males, of similar socioeconomic status, recruited from the community. Coping strategies between the two groups were compared using a Hotelling T^2 test. The results indicated that the alcoholic males differ from the non-alcoholic males on both dimensions of coping strategies, namely problem-solving and emotional focus. Personal attributes of alcoholics were also correlated with coping strategies to determine potential relationship of perceived social network and perceived career satisfaction. The results revealed no significant relationship. A central purpose was to increase understanding of the alcoholic patient

hospitalized in a community setting. Clinical implications are discussed relative to the results derived.

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Finally, I thank my family for the steadfast emotional support. Special assistance was provided by my extraordinary crew: Shelley Smith, Michael Cain, Frank Griffiths and Lillian Smith, who paddled when the sails lacked wind.

Dedication

This thesis

is dedicated to

my sailors:

James Jacobs

and Frank Griffiths

in remembrance of the seas we sailed together,

and of the shores

we left behind:

Aloha.

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Chapter 1

Personality Styles and Coping Strategies of Alcoholic Men

Introduction

How do coping strategies typically employed by alcoholics actually relate to their individual personality styles? From a broad perspective, alcoholics may show less flexibility than non-alcoholics in their coping patterns (Donovan & Chaney, 1985). As well, given the heterogeneity amongst the alcoholic population (Cox, 1987), it is reasonable to assume that coping strategies may be influenced by various personality styles.

Substantial research has been directed at identifying personality characteristics associated with alcoholic sub-types (Cox, 1979; Cox, 1987; Morey, Roberts, & Penk, 1987; Penk, 1981; Sutker & Archer, 1979). Although providing some level of assistance in planning treatment programs, frequently personality assessments require enhancement by the inclusion of other clinical data (Alfano, Nervanio, & Thurstin, 1987; Nervanio & Gross, 1983) and the identification of coping resources may be one such potential source.

Recent research in the area of alcoholic relapse prevention tends to underline the importance that cognitive variables play in alcohol consumption (Donovan & Chaney, 1985; Marlatte, 1979; Wilson, 1987). Of particular interest is a therapeutic intervention developed by Sanchez-Craig (1976) which is based

upon Lazarus' (1965) theory of psychological stress. In dealing with any stressful event two processes mediate the transactional relationship between the person and their environment: appraisal and coping. Appraisal involves the evaluation of what is at stake and what resources or options are available and coping involves any cognitive or behavioral efforts attempted, "...to master, tolerate, or reduce external and internal demands and conflicts among them" (Folkman & Lazarus, 1980, p. 223). Although the concept of assessing coping skills amongst alcoholic patients may be considered to be somewhat novel, the need for such an investigation is both practical and topical (Alfano, Nerviano, & Thurstin, 1987; Cox, 1987; Marlatte, 1985).

In terms of practicality, increasing costs to hospitals and the high rate of readmissions amongst alcoholic patients tends to suggest that psychological assessments require something more than the standard personality evaluations commonly employed (Sawka, 1985). In 1981, Canadians spent $5.28 billion on social costs generated by alcohol abuse and of that figure 64% was contributed by excess health care costs and social welfare costs (Sawka, 1985). Since Albertans currently spend 25% of the annual operating budget on health care (Sikand, 1988) while potential alcohol-abusing patients tend to be increasing (Lind, 1988), then any potential intervention to reduce costs amongst this noted group of high cost users of health care merits consideration.

Increasing accuracy in diagnosis appears warranted (Sawka, 1985), as does exploration of strategies that attempt to match individuals with treatment programs best suited to their personal resources (Miller & Hester, 1986; Sutker & Allain, 1988).

In regard to recent research interest in the alcoholism field, the current study draws upon resurgence in personality (Millon, 1984), clinical typologies (Alfano, Neriano, & Thurstin, 1987; Graham & Strenger, 1988; Morey, Roberts, & Penk, 1987; Sutker & Allain, 1988), and alcohol abuse in coping with stress (Glantz, 1987; Marlatte, 1985; Timmer, Veroff, & Colten, 1985; Wills & Shiffman, 1985).

In summary then, the purpose of this study is to investigate the relationship between personality styles and coping strategies amongst alcoholics who are currently admitted to a hospital treatment center. A brief review of the current literature follows. Included within this selected review are divisions attempting to address current thinking surrounding the major tenets of this investigation: personality and alcoholism, self-esteem, alcoholic sub-types, Millon Clinical Multiaxial Inventory, coping strategies, coping as a process, Ways of Coping Checklist and research questions with reformulated hypotheses. Subsequently in separate chapters the investigation procedures and findings are offered.

Chapter II

Literature Review

Various research investigations are presented hereafter to acquaint the reader with relevant background information. A brief introduction prefaces the personality research in alcoholism which includes pertinent literature concerning previous research, self-esteem, recent findings, sub-types, Millon Clinical Multiaxial Inventory, and summary. Coping strategies are prefaced by a brief introduction and followed by selected literature on coping as a process, Ways of Coping Checklist, and summary. Research questions and logically derived hypotheses conclude the literature review.

Introduction: Alcoholism and Personality

Given that alcoholism is a multidimensional concept of various contributing factors to dependence on alcohol (Kissin & Hanson, 1982), and assuming that a cognitive model of alcoholism contributes to understanding psychological vulnerability (Glantz, 1987), then consideration of the unique psychic systems of structures and functions (Millon, 1986) (i.e., personality) as they relate to individually appraised capacities to cope with particular psychosocial stressors (Lazarus & Folkman, 1984; Millon, 1986) (i.e., perceived resources identified in coping with stress), appears as fundamental to the current study.

Henceforth, the following selected literature is presented as a natural progression which led to current research questions and logically derived hypotheses.

An innovative clinical picture is beginning to emerge from the recent literature on alcoholism. Essentially, there is a shift from a unidimensional to a multidimensional concept of alcoholism. This latter view, proposes that genetic or physiological, psychological and social factors may all contribute, in varying degrees, to dependence on alcohol (Pattison & Kaufman, 1982). Alcoholism can be understood as a label used to observe and describe "drinking behavior and how it becomes problematic" (Helzer, 1987, p. 284). Specifically, alcoholism represents a pattern of pathological alcohol use over one month causing impairment in social or occupational functioning accompanied by withdrawal or tolerance (DSM-III; American Psychiatric Association, 1980). It has become increasingly apparent that efficient and effective treatment programs require focus on the "development and significance for the individual" (Cheaney, 1986, p. 7), and that contributions of various risk factors also need to be considered to enhance clinical data (Alfano, Nerviano, & Thurstin, 1987; Helzer, 1987). In addition to a significant evolution in alcoholism research in general, progress is also apparent in personality research amongst alcohol abusers.

Previous Alcoholic Personality Research

Historically, early personality research in alcoholism evolved from the psychoanalytic theorists. Profiling the alcoholic as an oral personality, they tended to emphasize dependency conflict as the impetus underlying alcohol abuse (Cox, 1979). Dependency and passivity dimensions were frequently cited as personality traits of alcoholics. The correlates of anxiety and depression were purportedly due to conflict of intense dependency needs and an equally-demanding compulsion to present a strong, independent image. In essence, the psychoanalytic perspective left many questions unanswered. In brief, two critical issues emerged from this theoretical disposition: trait exclusivity and a question of development (i.e., was this trait a cause or consequence of alcohol abuse) (Cox, 1979).

Over many years, prodigious studies amassed research on the alcoholic personality. Essentially, what has repeatedly been found is that there is no unique alcoholic personality (Carroll, 1982; Cox, 1987). Nonetheless, investigators still continue to employ various personality measures with alcoholics, but now in an attempt to identify various sub-types. Unfortunately, many studies in this area abound with inconsistencies which are frequently related to methodological difficulties (Nerviano, 1981). In a comprehensive review incorporating twenty years of accumulated research on the alcoholic, Cox (1979) concludes that alcoholics tend to represent a wide range of subtypes of which

prominent personality dimensions include: psychopathic deviation, depression, anxiety, passivity, and dependency. Of the latter two characteristics, Cox (1979) indicates that these are the most salient, commonly exhibited, "...both in terms of how they perceive the world around them and in terms of their interactions with other people" (p. 134).

Not attempting to diminish environmental-adaptability, the question of how alcoholics perceive themselves also appears relevant. Carroll (1982) proposes that the most discriminating characteristic of alcoholics is their low self-esteem. Similarly, Yost and Mines (1985) indicate that a failure identity is the most commonly exhibited characteristic amongst alcoholics.

Self-Esteem

Low self-esteem is frequently associated with dependency, passivity, anxiety and depression (Millon, 1986), which may or may not be secondary to alcohol abuse (Nace, 1987). For example, poor eating and sleeping habits, social stigmatization, and real losses may be influential in the level of depression experienced by many alcoholics (Nace, 1987; Nathan, 1988; Tarter, 1988). Similarly, Nathan (1988) concludes that the depressive symptomology appears to more frequently be: "reactive to the consequences of the abuse (or to be a product of the pharmacological actions of the abused drug) than to be antecedent" (p. 187), that is, reflecting behavior rather than

personality. In simplistic terms, the reality of "self" can be defined as a consequence of what one does and corresponding moods (from origins the individual may be unaware of) may subsequently be constructed to fit a dominant theme in the image of self (Gazzaniga, 1985; Gazzaniga, Steen, & Volpe, 1979). However, well-rehearsed behavioural patterns of learned helplessness may more closely correspond with the concept of a failure identity and suggest a more stable aspect of personality, preceding abusive consumptive patterns. Attempts to cope with stress repeatedly reaffirms the perception of personal inadequacies. Glantz (1987) proposes that the maladaptive cognitive contents and processes, frequently in concert with sensory processing dysfunctions, are acquired early in life and as children are often unnoticed or identified as a deviation. Then, exacerbated by the environment, maladaptive strategies and coping mechanisms which may have been adequate during adolescence, become noticeably inadequate in adulthood and in an attempt to cope with stress, the individual begins, then continues, to rely upon alcohol usage (Glantz, 1987). Given that this assumption is correct, then level of self-esteem or awareness of a failure identity would tend to be associated with the significance that reliance on alcohol (as a primary coping mechanism) has for the individual. Amongst adult children of alcoholics, Gilbert (1987) notes that growing up with an alcoholic typically provides a stressful early environment in which parental modeling of alcohol use in coping with stress, and easy access to alcohol, tends to

be associated with a 30% alcoholism rate. One feasible reason why the alcoholism rates amongst this population are not substantially higher may be in the acquisition of resilient characteristics (Berkowitz & Perkins, 1988). That is, their sense of self is not compromised by their early experience with parental alcoholism. In particular the non-alcoholic, male offspring tend to reflect independence and autonomy in problem-solving abilities and in general, report less self-depreciation than their female counterparts (Berkowitz & Perkins, 1988). To assume that all alcoholics have low self-esteem or that all are aware of a failure identity appears shortsighted even though such characteristics have been commonly identified amongst alcohol abusers (Carroll, 1982). In the present study, personality profiles, as measured by the MCMI (Millon, 1983) may typically reflect level of consistency of low self-esteem within the group of alcoholic men.

While it may be argued that commonalities exist amongst the heterogenous population of alcoholics, at the same time, substantial individual differences exist not unlike that which is found amongst a normal population. Recent theoretical trends suggest that individuals drink for different reasons, revealing different personality characteristics, although typically drinking tends to be initiated to control positive affect, (i.e., enhancing mood and self-esteem), which over time tends to

progress to drinking to control negative affect (i.e., withdrawal symptoms)during maintenance (Cox, 1987; Marlatte, 1987).

Recent Alcoholism and Personality Findings

In considering previous research, the cross-study inconsistency appears partly to be related to lack of control for age, and socioeconomic status (SES). Frequently subjects, selected from American Veteran hospitals, tended to represent lower SES groups with somewhat limited social resources. Since older research studies assumed a unidimensional concept of alcoholism (i.e., the disease or conflict model), then pooling subjects appeared reasonable. However, recent theoretical formulations represent a perspective which is termed "adaptational," in that alcohol expectancies are unique to the individual (i.e., may be relied upon as a primary coping mechanism to alter mood, environment, interpersonal relationships, or perception of self, which in a sense tends to facilitate or substitute normal functioning) and which is central to all cognitive based theories of alcoholism (Glantz, 1987; Mann, Chassin, & Sher, 1987; Wilson, 1987). Therefore, current investigations of alcoholic personality factors logically require control for level of social resources. In the present study, careful attention to monitoring social resources has been provided.

In addition to theoretical advancements which now consider multiple factors as contributors to alcoholism and the treatment

thereof (Helzer, 1987; Nathan & Skinstad, 1987), multiple personality types have been investigated by using multivariate research designs, and some gains have been made in grouping types of alcoholics into personality classifications. Amongst male alcoholics, Conley (1981) was able to identify four basic sub-types: classic alcoholic, neurotic, psychotic, and psychopathic. When he included women alcoholics, the types revealed from the Minnesota Multiphasic Personality Inventory (MMPI) included: classic alcoholic, neurotic, psychopathic, and schizoform (Conley & Prioleau, 1983). To control for gender of the alcoholic is evidently very important and was therefore done in this study.

Male Alcoholic Sub-Types

Identifying sub-types or prototypes as well as inclusion of additional personal data appears to be progressive in elaborating the personality picture of the individual alcoholic (Nervanio & Gross, 1983). In a recent review of the literature, Nervanio and Gross (1983) derived several prototypes which included the following: chronic severe distress, passive-aggressive, sociopathic, antisocial, acute reactive depression or classic alcoholic, and mixed character dysphoria. Essentially, Nerviano and Gross (1983) indicated that of the prototypes discussed in the literature two main categories emerge. The two categories are a hostile-rebelliousness group and a hypochondriacal group.

Interestingly Cox (1987) also proposes a very similar basic split into a psychopathic type and distressed-neurotic type, which may represent two principal sub-types of primary and secondary alcoholics. Morey, Roberts and Penk (1987), on the other hand, proposed a basic personality configuration, typified by depression, alienation, anxiety and impulsiveness, with the differentiation of subtypes revealed by elevation of profiles, varying as a function of severity of alcohol dependence. In other words for Morey, et al (1987), there exists a number of qualitative differences which may modify a personality profile, such as drinking pattern, interpersonal style, and family environmental differences, yet as well, some level of consistency in configuration, within which various subtypes may be found. While it appeared reasonable that some of the prototypes noted by Nerviano and Gross (1983) could be found amongst the community hospital alcoholics in the current study, it was also apparent that all pure types would not likely be identified due to the nature of the patients studied. That is, lack of severely impaired patients and lack of low SES patients could possibly reveal a different, overall, patient profile.

In controlling for the age of the alcoholic, Swain and Thorne (1984) found that typically younger individuals fell into the psychotic and psychopathic sub-types, whereas older alcoholics more readily assumed the neurotic and unclassified

typologies. Similarly, Delatte and Delatte (1984) found that younger alcoholics tended to represent the sociopathic types, while the older individuals emerged as hypochondriacal in their personality characteristics. It is assumed that age is a factor that modifies or levels out deviant tendencies (Cox, 1987). Therefore, the current study included the age range from 20 to 65 years, which may have excluded some level of sociopathic types, yet was intended to reduce contaminants of poly substance abusers. An abuser group was recently identified by Alberta Alcohol and Drug Abuse Commission (AADAC) amongst the younger alcoholics (Slavik, 1987). That is, the younger age group frequently employ in addition to alcohol, substances such as cannabis, cocaine, crack, heroin, amphetamines and LSD, which are commonly identified drugs amongst Canadian abusers (MacLennan, 1987).

While various personality assessment instruments have been employed in the investigation of alcoholic personalities, the MMPI has most commonly been utilized and not without criticism. Kunce (1979) suggested that while most alcoholic profiles may be categorized as neurotic, sociopathic, or psychotic, typically the focus of interpretations involves psychopathology with scant regard to positive resources. Clearly alternatives need also be considered which not only reveal psychopathology but bring into focus positive assets. That is the direction of this research and the rationale behind the alternative instrumentation.

Millon Clinical Multiaxial Inventory

One relatively recent device appears particularly promising for assessing interpersonal relationships, personality traits, and coping styles. The Millon Clinical Multiaxial Inventory (MCMI) (Millon, 1983), although comparatively new to the alcoholism research area appears to be well received and useful, particularly amongst experienced practitioners (Siddall, 1986). The MCMI provides measures of eight basic personality styles, three severe personality disorders, and nine symptom clusters.

One outstanding feature of the MCMI is the theoretical foundation. Unlike many psychological assessment instruments, including the MMPI, the MCMI has potential to help elucidate a level of confusion frequently encountered in assessing the alcoholic patient. One of the major difficulties encountered is attempting to distinguish between psychiatric symptoms that occur from the use of alcohol and those that initiate the use (Waldinger, 1986). In appreciating the complexity of this task, Millon (1986) provides substantial theoretical insight. Personality is defined as: "a psychic system of structures and functions which parallel those of the body" (p. 643). The structures of a more stable nature include internalized memories and self-images. The functions typically include unconscious mechanisms and cognitive processes. Comprising a system, the distinctive configuration provides: "a template and disposition

for maintaining psychic viability and stability" (p. 643). Correspondingly, a disorder occurs when there is a failure in the system's "dynamic pattern of adaptive competencies," or, as a lack of "capacity to cope with particular psychosocial stressors" (p. 643). Elaborating on the maladaptive end of the normality-pathology continuum of personality, Millon (1986) indicates that three features serve to differentiate maladaptiveness: (1) lack of flexibility in relating to others, expressing feelings, or for resolving stress and conflict; (2) lack of ability to break out of vicious circle of habitual behavioral and thinking patterns which tend to intensify the existing problems; and (3) lack of resilience under conditions of subjective stress.

In relating Millon's (1986) theoretical model to alcoholic personalities, advantages exist in discerning more stable patterns (structures) from the more transient symptoms or state (functions). That is, what may appear initially to be a personality disorder may well be (under scrutiny) a transient symptom associated with withdrawal from alcohol. Any potential resources may be unidentified, overshadowed by what appears to be more stable psychopathology. More severe forms of psychopathology can also be distinguished from those of lesser severity. In accordance with the personality continuum model,

degrees of normality or resources appear susceptible to identification as well as degrees of psychopathology.

Not inconsistent with previous studies, research with the MCMI amongst alcoholics reveals a few seminal studies which are interesting and may elucidate the current study. Craig, Vernis, and Wexler (1985) in investigating the personality differences between drug addicts and alcoholics found that alcoholics distinguished themselves in the following personality styles: avoidant, dependent, schizotypal, borderline, and paranoia. The latter three more severe categories included individuals presenting as more organically impaired. Age of the subjects was not found to be influential, yet the SES level could not be ruled out as a confounding variable.

The MCMI is without doubt a modern, well-designed device, more in tempo with the standards for psychological instruments as advocated by the American Psychological Association. It therefore is employed for the present investigation.

The MCMI appears to offer potential in identifying alcoholic sub-types. In another study of male veteran alcoholics, Bartsch and Hoffman (1985) indicated that a cluster analysis produced meaningful groups from the MCMI data which was mainly consistent with the Nerviano and Gross (1983) and the Conley (1981) investigations employing the MMPI as a personality measure. Of interest, a clearly neurotic sub-type was absent amongst this

sample of primarily disadvantaged and severely impaired men. The five groups identified included the following sub-types: classic alcoholic or acute reactive depressive, psychopathic or anti-social sociopath, psychotic or paranoid-alienated, psychopathic (subdued variant) or passive-aggressive sociopath, and a chronic severe distress group.

The MCMI, in addition to revealing subtle changes in both Axis II (i.e., more stable features) and Axis I (i.e., more transient features) of the individual profiles over time, is also useful in discriminating improvements or resources. Amongst inpatient alcoholics administered the MCMI at intake and again at one month into treatment, McMahon, Flynn, and Davidson (1985) found that the alcoholics revealed significant mean changes during the time lapse on each of the eight basic personality scales plus two of the pathological personality scales. In essence, decreases were noted on the following scales: schizoid, avoidant, dependent, passive-aggressive, schizotypal-schizoid, and borderline. Interestingly, increases were also evident on the histrionic, narcissistic, antisocial, and compulsive scales. These increases were interpreted as improvements in the following related areas: sociability, self-image and expanded cognitive outlook, social conformity, and appropriate life-style structuring. Of note, even though the personality scales typically reflect more stable aspects of an individual's

personality, this study indicated significant changes only after one month into treatment. In addition, although the alcoholics showed significant mean elevations on the symptom scales of anxiety, dysthymia and alcohol abuse at intake, the only mean elevation after one month was the alcohol abuse scale. Whether or not the demographics of inpatient alcoholics was influential in the patterns of inconsistency and change found was not determined. The men were predominantly white with an average age of 41 years, and an average grade 12 level of education which may reflect a level of coping resources perhaps not available in the previously mentioned MCMI studies.

Summary

As previously mentioned former research efforts directed at identifying personality characteristics have frequently provided inconsistent or narrow results. That is, the results are narrow when scant consideration is provided for resources accompanying a pathological label. A central question, emerging from current literature is: How do the prototypical personality styles relate to perceived coping strategies specifically amongst a non-severely-impaired, middle-class, group of inpatient alcoholics?

Introduction: Coping Strategies and alcoholism

Coping strategies provide a useful construct in enhancing understanding of the individual alcoholic (Claxton, 1986;

Marlatte, 1985; Shiffman & Wills, 1985). Millon (1986) indicates that coping styles may be limited by personality factors which tend to provide a template or disposition for level of adaptiveness (i.e., flexibility). Coping as process reflects the individual's appraisal of cognitive and behavior activity which includes use of both problem-solving and emotional-regulating efforts in coping with recent stressors. The propensity to utilize both the problem-solving and emotional-focused efforts constitutes a resource in dealing with stressors encountered in everyday living (Lazarus & Folkman, 1984), and it is this cognitive inclination, rather than an actual behavioral observation, that is being scrutinized and represents a major tenet within this current study.

Coping Strategies

Logically, stress is perceived differentially. A person's reaction to stress typically involves, "a complex interaction of perceived control, actual control, learned coping skill, range of coping alternatives, and an attitude of openness and flexibility" (Yost & Mines, 1985, p. 79). Amongst non-alcoholic or stress-resistant individuals, there is a tendency to be flexible in their attachments to goals and to other people. Certain personality styles and coping resources enable these individuals to shift to new goals and relationships when established ones have become impossible to pursue (Yost & Mines, 1985).

Inflexibility, on the other hand, tends to contribute to self-defeating behavior and serves to promote a level of vulnerability under stressful conditions (Millon, 1986). For the alcoholic, habitual use of alcohol tends to constrain the opportunity to learn and develop, and thus maintains lack of variability in attempting to cope with stress or challenges encountered, both socially and vocationally. However, not withstanding the physiological influence of the narcotic alcohol, which once initiated typically contributes to stress (Grunberg & Baum, 1985; Peyser, 1982), the alcoholic nonetheless frequently reveals a low self-concept or failure identity (Forrest, 1985) which is purported to predispose them to maladaptive coping strategies. That is, as a child the alcoholic has, in a sense, been treated as a "failure", which is reinforced and exacerbated through multiple subsequent experiences of failure and inadequacies (Forrest, 1985). However, not all alcoholics necessarily perceive themselves as failures in coping with stress. For example the antisocial or the narcissistic type logically tend to see themselves in a more favorable identity, (i.e. well skilled in manipulating their environment), and it appears reasonable to assume that not all failure-identity individuals become alcoholic. Is a negative perception of early family experiences more inclined to be associated with a more restricted or less flexible coping style as an adult? While parental care enhances

child development, people continue to learn from others throughout their life time. Are positive social and vocational relationships maintained as an adult equally as influential as the perceived quality of early family relationships in promoting flexible coping strategies?

Perhaps it is not so much in knowing whether or not a given social network exists, or that observers label a relationship as positive or negative, but rather how the individual perceives the relationship. That is, how meaningful a given set of resources or stressors are to the individual may be equally important in determining a person's current level of coping strategies.

The MCMI (Millon, 1983) and the Millon Behavioral Health Inventory (MBHI) (Millon, Green & Meagher, 1982) both reveal a particular interpersonal coping style along with personality, and symptomology characteristics. Cohen and Lazarus (1983), however, indicate there is a substantial difference between coping as a trait or style and coping as process. Trait suggests responding in a specific way to stressful situations, whereas style implies a pervasive way a person relates to the world. Coping as process, on the other hand, refers to what an individual actually does and how it changes over time. Furthermore, amongst non-alcoholic patients, Cohen and Lazarus (1983) indicate that correlations between trait and process measures of coping tend to be quite low.

Coping as a Process

Coping as a process is understood as an ongoing transaction between the person and the environment wherein different types of strategies are employed throughout the process of attempting to cope. Coping typically involves appraisal and reappraisal as the situation unfolds, utilizing both problem-solving and emotional-regulating efforts.

Traditionally, most coping research has been directed at identifying styles or traits, which have in effect been inefficient in predicting actual coping strategies (Lazarus & Folkman, 1984). Essentially Lazarus and Folkman (1984) argue that the difficulty inherent in the measurement of traits or styles evolves from the assumption that people do not reappraise or alter their course in attempted response to an appraised stressor. Other than directly observing how people cope, Lazarus and Folkman (1984) indicate that having individuals reconstruct recent stressful events and describe what they thought, felt and did represents an alternative means of measurement.

Ways of Coping Checklist

The Ways of Coping Checklist (Lazarus & Folkman, 1984) is a recently developed instrument, which includes 67 items involving direct action, inhibition of action, information search, and intrapsychic or cognitive coping. Each item is scaled from "not used" which equals zero, to "used a great deal" which equals 3,

providing a measure of intensity as well as frequency of items endorsed. Of the two major functions of coping, problem-solving is comprised of strategies such as generating several solutions to a problem, gathering information, and making a plan of action and following it through. Emotion-focused coping typically includes pursuing emotional social support, distancing, avoiding, reframing positive aspects, and self-blame. To enhance validity, repeated measures over three stressful contexts (i.e., work related, family or social related and health related) have been employed (Folkman & Lazarus, 1980).

Although not previously used amongst alcoholics, the Ways of Coping Checklist (WCCL) (Lazarus & Folkman, 1984) was used in research amongst 100 community adults, over a 12 month period. Folkman and Lazarus (1980) found that 95% of their population showed variability, that is used both problem-solving coping and emotional-focused coping in attempting to manage stressful situations occuring in every day life. Over the three contexts (i.e. work-related, family-related, and health-related) the community adults differed slightly but not significantly in that work-related stress elicited more problem-solving responses whereas health tended to reveal more emotion-focused coping. No significant difference was found for age level.

In a recent stress management study, Martelli, Auerbach, Alexander, and Mercuri (1987) provided three types of

intervention (i.e., problem-solving, emotional-focused, and both) to 46 patients about to undergo preprosthetic oral surgery. WCCL was used in identifying individual coping patterns and matched to intervention with the exception of the mixed intervention. Results indicated that the mixed focus intervention produced the best results to surgery, and that the differential response to problem-solving and emotional-focused intervention suggested that emotional-focused coping may be more useful to patients where the outcome cannot be controlled and must be accepted. Furthermore, they stated that emotional-focused coping might be more useful in the earlier stages of coping, whereas the later stages of coping elicited more problem-solving coping for influencing long-term outcome.

In the current study, the WCCL is employed as a measure of appraised coping strategies using the Folkman and Lazarus (1980) technique of repeated measures over three stressful contexts (i.e., in resolving: a recent health stressor, a recent work stressor, and a recent family or social stressor).

Perhaps with alcoholics, they may see most stressors as uncontrollable or they may direct their energies towards attempting to maintain a level of self-esteem and consequently use fewer resources in terms of long-term consequences (i.e., utilize more emotional-focused strategies and less problem-solving strategies). It appears reasonable to assume

that personality differences may be influential in this regard.

Commonly, research in the alcoholism field reveals alcoholics to have deficits in social skills, in assertiveness skills, and in ability to communicate feelings (Donovan & Chaney, 1985). Furthermore, in terms of relapse, Donovan and Marlatte (1980) propose that appraisal of a high risk situation, in conjunction with decreased perception of self-efficacy as well as positive expectancies regarding the effects of alcohol, are typically associated with alcohol consumption. Sanchez-Craig (1976) indicates that when alcohol is consumed as an aid to cope with appraised stressful events or to increase confidence in ability to cope, drinking may become habitual and interfere with development of more adaptive responses. However, treatment tends to be efficiently initiated when the alcoholic is forced to reappraise the deleterious effects of alcohol consumption, and offered an opportunity to acquire alternative coping strategies.

Although the typical coping styles of alcoholics appears to represent one of rigidity as well as a lack of skills, the research in general shows a lack of consideration for individual differences. Paradoxically, Emery and Fox (1981) indicate that in terms of problem-solving or goal orientation, alcoholics in attempting to maintain their drinking habits, reveal "amazing strength, initiative, and perseverance" (p. 184). Is it likely

that there are degrees of deficits (or rigidity) as well as degrees of resources amongst the alcoholics?

Summary

In essence, the research literature has in general been directed towards coping traits or styles and the concept of coping as a process represents a novel perspective. Amongst alcoholics, there is a tendency to view their coping strategies as consistently rigid, or at least, deficient. The current study asks how do the alcoholics interpret their coping strategies?

Research Questions

The preceding review gives rise to certain underlying questions. A summary of those questions follows. Thereafter, the questions reformulated as testable hypotheses are listed.

1. How do personality styles relate to appraised coping strategies amongst alcoholic patients?
2. How do personal attributes relate to appraised coping strategies, amongst alcoholic patients?
3. How do the appraised coping strategies of alcoholics relate to the appraised coping strategies of non-alcoholics?

Hypotheses

Testable hypotheses derived from the preceding questions include the following:

Hypothesis 1

The personality style of the alcoholic males will be related to their coping strategies.

Hypothesis 2

Level of perceived social support will be related to frequency of appraised coping strategies.

Hypothesis 3

Level of career satisfaction will be related to frequency of appraised coping strategies.

Hypothesis 4

Appraised coping strategies of alcoholics will differ from the appraised coping strategies of non-alcoholics, both in terms of frequency and in problem-solving efforts.

Chapter III

Method and Procedures

Data collection and interpretation mainly focused upon personality characteristics and coping strategies. Scores for both these dimensions were obtained through self-report questionnaires. Alcohol abuse reported by hospital charts was confirmed by a base rate score of 75 on the MCMI: Axis 1: Alcohol abuse scale. The Short Michigan Alcoholism Screening Test (SMAST), developed by Selzer, Vinokir & Van Rooijen (1975), was also used to measure alcohol abuse tendencies. Scores exceeding five, indicate alcoholism (Selzer, et al., 1975). Validity, in terms of concordance to clinicians' assessments, indicates a 93% "true positive" response rate (Westermeyer, 1976). In order to control for potential confounding influences, this study is restricted both to male and nonpsychotic individuals. Women tend to show distinctive patterns in reason for drinking (Cox, 1979) and in response to treatment (Gomberg, 1982); the latter category of individuals excluded appears reasonably self-evident. Scrutiny of hospital charts provided pertinent information regarding psychotic behavior.

Inclusive to this study are demographic and personal variables which were collected through the Questionnaire (See Appendix A). SES was ascertained through data on occupational and educational responses from which a Canadian Occupational

Prestige Index (Eichler, 1976) was used in determining each individual's level of social class. Marital and friendship status were also included as potential resources. The age range included individuals from 21 to 60 years of age, since the average age of alcoholics seeking admission to treatment at AADAC in 1985 was 34.8 years, with younger than 20 years presenting as poly drug abusers (Slavik, 1987).

Procedure and Method

A. Procedure

Subjects were provided with a certificate of informed consent, prefacing each questionnaire (See Appendix A), and were consistently informed of the following aspects: confidentiality, voluntariness, and the nature and purpose of this study. After responding to any questions, the interview and completion of the questionnaire lasted between 1-1/2 and 2 hours. Interviews conducted with the subjects who were hospitalized were asked if admission was precipitated, in concert with their physician's recommendation, by suggestions from significant others, or through their own volition. All patients except one indicated affirmation of admission through their own volition.

B. Sample

Subjects for this study were volunteers from two major sources. The first group was recruited as consecutive admissions to two community hospitals. Individuals who met the criteria and

agreed to participate were selected for this study. Of 50 male admissions to psychiatry with a history of alcohol abuse, 35 produced valid results and met criteria requirements.

Non-alcoholic volunteers from various occupational groups in the community constituted the second group of 35 men. These individuals were recruited through a variety of social associations and care was taken to select men with a middle-class socioeconomic background.

Statistics concerning the subject characteristics are presented in detail in Chapter 4, Results. Briefly the alcoholic group was composed of men ranging in age from 21 to 60 years. The occupations represented ranged from semi-skilled to professional. The non-alcoholic group of men ranged in age from 21 to 57 years. The occupations represented by the second group ranged from semi-skilled to professional and are presented in detail in chapter 4, Results.

The MCMI

The MCMI was used to assess personality characteristics. Scales 1 through 8 assess basic personality styles of a more stable nature. Scales 9 through 11 assess chronic, pathological personality styles. Symptomatic or transient characteristics are revealed in scales 12 through 20. Reliability is estimated at .80 correlation over a 5 week period. In terms of validity, base rate (BR) scores equal to or exceeding a cutoff of 75, indicate a

percentage range of 78 to 94 correct classifications over all 20 scales (Millon, 1983). Externally, convergent patterns exist with comparable diagnostic inventories including the MMPI. Moderate elevations approaching the 75 cutoff were construed as tendencies, whereas marked elevations, exceeding an 85 cutoff revealed more predominant patterns of personality characteristics. Relatively short with 175 questions, this self-administered instrument was frequently favorably received amongst patients. The MCMI (Millon, 1983) was hand scored, with adjustment and raw score equivalences calculated according to the MCMI Manual.

The WCCL

The Ways of Coping Checklist (WCCL) (Lazarus & Folkman, 1984) was used to assess appraisal of coping strategies indicating level of problem-solving (P) focus versus level of emotional (E) focus, plus an overall frequency measure of coping strategies employed. Three stressful contexts of stressors are measured using the same instrument (i.e., work related, family or social related, and health related). In terms of reliability, Folkman and Lazarus (1980) report a 95% consistency pattern amongst 100 community adults over a 12 month period. That is, these individuals employed both problem-solving and emotional focused coping strategies in coping with hassles or stressors encountered in every day life, 95% of the time, over the course

of a year. With regard to validity, internal consistency of the P/E classifications represented an interater correlation of .95. In addition, a principal factor analysis using a varimax rotation lent support for rationally derived scales within the two major factors (i.e., P/E). Furthermore, Folkman and Lazarus (1980) also indicated that the correlations between the P and E scales demonstrates sufficient variance not shared by both to support their independent use (i.e., over three administrations, the mean r^2 equalled .19). The WCCL was hand scored in accordance with the Folkman and Lazarus (1980) study.

The MBHI

In addition to the MCMI and the WCCL, the Millon Behavioral Health Inventory (MBHI) (Millon, Green, & Meagher, 1982) was used in assessing coping styles. This instrument was developed to assess a wide range of clinically relevant behaviors amongst physically ill patients, and include four categories of 20 scales: basic coping styles, psychogenic attitudes, psychosomatic correlates, and prognostic indexes. For the purpose of this study, the coping styles (scales 1 to 8) was correlated with the WCCL results, comparing the more stable styles of coping to the more variable strategies of coping revealed by the WCCL. In regard to reliability, the test-retest correlation mean over a 4 month interval is reported at r=.82 (Green, 1982). In terms of validity, KR20s used to estimate

internal consistency ranged from r=.66 to .90. In addition, the MBHI is also reasonably consistent with similar inventories and correlational data is reported at length in the MBHI manual (Millon, Green, & Meagher, 1982). The MBHI was hand scored, with adjustment and raw score equivalencies calculated according to the MBHI (3rd Edition) Manual (Millon, Green, & Green, 1982).

Social/Demographics

Demographics/personal attributes were collected through the Questionnaire. Quality of social network was revealed through an index formed by averaging questions numbers 5, 6, and 11. Quality of career or job satisfaction was revealed through question number 3. Perception of quality can range from a low, zero to a high three. Questions regarding a recent major life stressor and physical health were also included in the questionnaire, as rationally-derived influences which could confound results.

All questionnaires were administered and scored by the researcher. Although a single session with a subject was usually sufficient in collecting data, and two hours was typically the maximum time to complete the package, some repeat visits were necessary where hospital routine intruded on data collection.

Data Analysis

The data was analyzed as follows:

1. Hotelling T^2 tests were conducted between alcoholics and non-alcoholics on personality variates as a first level of analysis.

2. Pearson correlations were calculated between personality variates and coping strategies amongst alcoholics.

3. One way analysis of variance was conducted on coping strategies of alcoholic prototypes.

4. a) Correlations were calculated between social support and coping strategies amongst alcoholics.

   b) Correlations were calculated between career satisfaction and coping strategies amongst alcoholics.

5. Hotelling T^2 tests and t-tests were conducted on coping strategies between alcoholics and non-alcoholics.

6. Chi squares and t-tests were computed for subject characteristics.

Criterion significance was set at .05.

Chapter IV

Results

Offered hereafter is a presentation of the hypotheses that were tested followed by findings appropriate to each hypothesis. Specific characteristics of the alcoholic and non-alcoholic groups are presented in summary.

A. Hypotheses tested for significance

For the ease of reader reference, hypotheses will be restated, followed by the findings reported and the conclusions which the findings support.

Hypothesis 1

The personality style of the alcoholic males will be related to their coping strategies. The findings indicate that the personality styles of alcoholic males reveal significant relationships with coping strategies. As well personality styles of the alcoholic males show significant differences in contrast to their non-alcoholic counterparts. Several unique personality styles were identified suggesting concordance with prototypes previously reported in the literature.

Hotelling T^2 Test: MCMI/MBHI: 2 Groups

The Hotelling T^2 test was employed in the first level of analysis to distinguish personality variates unique to the alcoholic group. The means and standard deviations (SD) and Hotelling T^2 test values are revealed in Table 1 for the total of

70 males. A review of the results in Table 1 indicate that in the MCMI, Axis II, the alcoholics differ significantly from the non-alcoholics in several personality dimensions: Schizoid (1), P=.000; Avoidant (2), P=.000; Passive-Aggressive (8), P=.000; Schizotypal (S), P=.000; Borderline (C), P=.000. Similarly in the MCMI, Axis I, the alcoholics demonstrate scale evaluations significantly in contrast to the non-alcoholics as follows: Anxiety (A), P=.000; Dysthymia (D), P=.000; Alcohol Abuse (B), P=.000; Psychotic Thinking (SS), P=.000; Psychotic Depression (CC), P=.000. Figure 1 represents a concise contrast between the two groups. Clinically significant features reveal the total group of alcoholics as showing moderate elevations of schizoid and borderline tendencies, whereas avoidant, dependent, passive-aggressive, anxiety, dysthymia and alcohol abuse approximate marked or clinically significant elevations.

Table 1

Means and Standard Deviations of Personality Variates with Hotelling T^2 - test Values for Alcoholic and Non-Alcoholic Groups *p=<.05

Variables	Alcoholic M	Alcoholic SD	Non-Alcoholic M	Non-Alcoholic SD	T^2	F	DF^1	DF^2	Probability	
MCMI AxisII										
1. Schizoid	75.82	27.17	29.83	18.06	59.04	4.58	11	58	0.00	*
2. Avoidant	81.80	28.72	22.23	17.42	110.09	8.54	11	58	0.00	*
3. Dependent	76.43	26.09	46.54	24.50	24.40	1.89	11	58	0.06	
4. Histrionic	46.14	21.27	66.83	20.71	16.99	1.32	11	58	0.24	
5. Narcissistic	45.51	22.47	66.57	11.34	24.50	1.90	11	58	0.06	
6. Antisocial	54.03	24.20	58.74	17.74	0.86	0.07	11	58	1.00	
7. Compulsive	44.54	21.30	63.89	13.52	20.58	1.60	11	58	0.12	
8 Passive-Aggressive	81.74	26.68	23.54	15.44	124.74	9.67	11	58	0.00	*
S Schizotypal	61.77	16.84	38.83	16.19	33.77	2.62	11	58	0.00	*
C Borderline	70.54	15.80	34.97	18.61	74.30	5.76	11	58	0.00	*
P Paranoid	59.74									

Table continues . . .

Table 1 continued

Variables		M	SD	M	SD	T^2	F	DF^1	DF^2	Probability	
Axis I											
A	Anxiety	91.43	22.03	42.91	22.02	84.90	8.32	9	60	0.00	*
H	Somato Form	68.63	19.85	47.26	19.25	20.91	2.05	9	60	0.05	
M	Hypomania	44.69	30.05	37.91	28.57	0.93	0.09	9	60	1.00	
D	Dysthymia	84.40	23.45	43.91	18.81	63.50	6.23	9	60	0.00	*
S	Alcohol Abuse	83.51	7.57	32.66	14.53	337.39	6.23	9	60	0.00	*
T	Druge Abuse	67.60	15.42	49.60	23.00	14.79	1.45	9	60	0.19	
SS	Psychotic Thinking	64.17	11.73	36.97	14.53	45.56	4.47	9	60	0.00	*
CC	Psychotic Depression	66.00	25.34	25.34	18.35	84.18	8.25	9	60	0.00	*
PP	Psychotic Delusions	61.54	17.10	46.00	18.50	13.32	1.31	9	60	0.25	
MBHI - Basic Coping Styles											
1)	Introversive	33.06	31.58	60.46	22.15	5.55	0.86	8	61	0.53	
2)	Inhibited	87.00	24.74	37.23	19.22	27.23	4.20	8	61	0.00	*
3)	Cooperative	50.91	29.82	52.97	25.39	111.44	17.21	8	61	1.00	
4)	Sociable	15.71	19.41	65.29	17.64	125.04	14.02	8	61	0.00	*
5)	Confident	19.91	20.78	49.43	20.03	36.60	4.10	8	61	0.00	*

Table continues . . .

Table 1 continued

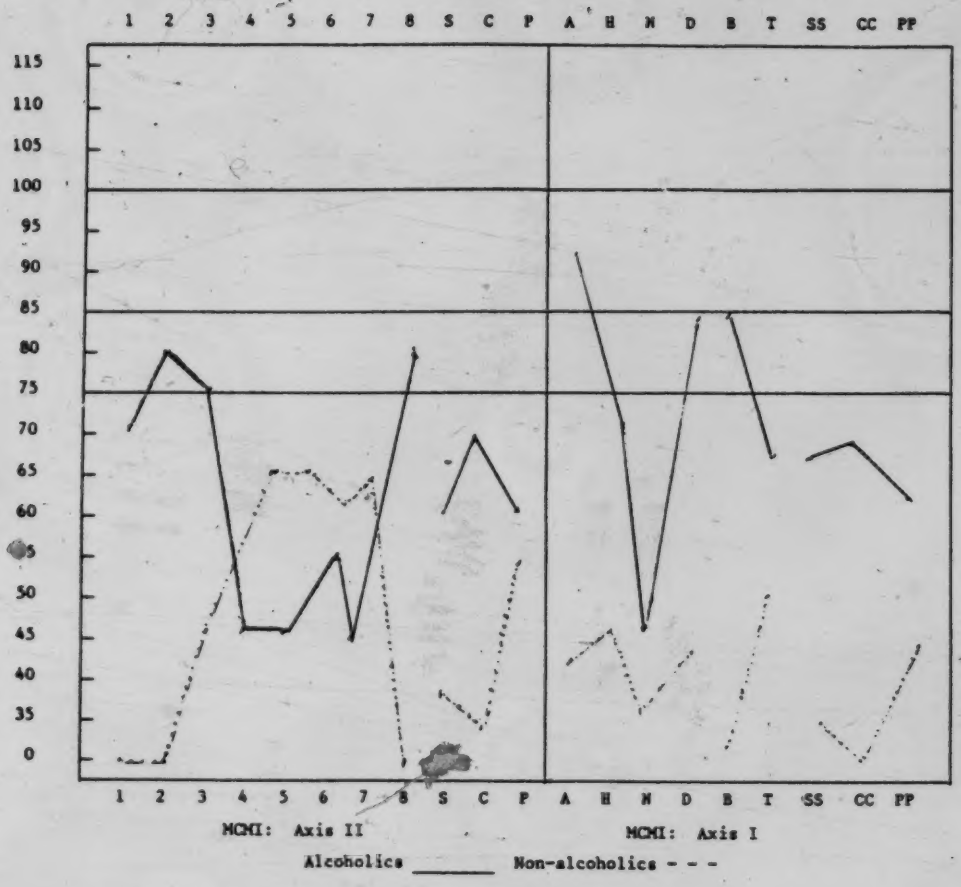
Variables	M	SD	M	SD	T^2	F	DF^1	DF^2	Probability	
6) Forceful	43.29	31.72	37.43	24.69	0.74	0.08	8	61	1.00	
7) Respectful	44.91	20.53	47.34	14.17	0.33	0.04	8	61	1.00	
8) Sensitive	79.23	30.30	26.17	20.55	73.52	8.24	8	61	0.00	*
Psychogenic Attitudes										
A Chronic Tension	49.29	27.91	35.20	21.75	5.55	0.86	3	66	0.53	
B Recent Stress	60.66	22.97	32.77	21.72	27.23	4.20	3	66	0.00	*
C Premorbid Pessimism	67.46	16.41	22.69	18.98	111.44	17.21	3	66	0.00	*
D Future Despair	66.00	17.15	25.40	17.28	97.33	15.03	3	66	0.00	*
E Social Alienation	61.80	18.33	26.66	20.35	57.64	8.90	3	66	0.00	*
F Somatic Anxiety	67.06	20.44	22.60	18.47	91.15	14.08	3	66	0.00	*
Psychosomatic Correlates										
MM Allergic Inclination	66.00	15.24	36.37	16.06	62.67	20.28	3	66	0.00	*
NN Gastrointestinal Susceptibility	73.91	13.24	34.57	10.52	189.52	61.31	3	66	0.00	*
OO Cardiovascular Vulnerability	77.31	20.16	40.11	15.83	73.74	23.86	3	66	0.00	*

Table continues . . .

Table 1 continued

Variables	M	SD	M	SD	T^2	F	DF^1	DF^2	Probability
PP Pain Treatment	78.17	25.50	23.20	18.39	107.01	34.62	3	66	0.00 *
QQ Life Threat Reactivity	77.31	20.27	32.09	18.15	96.74	31.30	3	66	0.00 *
RR Emotional Vulnerability	51.23	31.30	8.86	15.96	50.90	16.47	3	66	0.00 *

Figure 1



Schizoid
Avoidant
Dependent
Histrionic
Narcissistic
Antisocial
Compulsive
Passive-Aggress
Schizotypal
Borderline
Paranoid
Anxiety
Somatoform
Hypomania
Dysthymia
Etoh Abuse
Drug Abuse
Psychotic Thinking
Psychotic Depression
Psychotic Delusions

In contrasting the 2 groups on the MBHI, which is typically used amongst a nonpsychiatric patient population, the following personality variates distinguished the alcoholic males: Basic Coping Styles: Introversive (1), P=.000; Sociable (4), P=.000; Confident (5), P=.000; Premorbid Pessimism (C), P=.000; Gastrointestinal Susceptibility (NN), P=.000; Emotional Vulnerability (RR), P=.000. Figure 2 represents the 2 groups as contrasting profiles. In terms of clinical significance, the coping styles of the alcoholics tend to reveal marked evaluations in inhibited and sensitive styles in addition to clinically-significant low representations in sociable and confident styles. In regards to psychogenic attitudes, moderate elevations are approximated in the areas of premorbid pessimistic, future despair, and social alienation. Moderate tendencies are also noted in the psychosomatic correlates of gastrointestinal susceptibility and cardiovascular tendency. Similarly, moderate elevations are revealed in the prognostic indices of pain treatment responsivity and life threat reactivity. In brief, statistically significant differences are discernible between the two groups of men as revealed by the personality variates of the MCMI and the MBHI. In terms of clinical significance figures 1 and 2 also reveal noteworthy differences in profile patterns.

Correlations: MCMI, AXIS II

Having determined distinguishable personality differences between the 2 groups of men, the next level of analysis involved computation of Pearson Correlation Coefficients between all personality variables and coping strategies of the alcoholic group. Table 2 reveals the pattern of significant correlations emerging from this data analysis. The overall pattern suggests a general bias towards emotional-focused (or emotional regulating) strategies, yet there also appears some noteworthy differences. Within the MCMI, Axis II, personality variables which tend to represent more relatively stable aspects of personality dimensions, some interesting differences emerge. Individuals endorsing scale (1) Schizoid items reveal a preference for emotional-focused strategies within a social context stressor, $p=.012$, and a moderate overall tendency within the composite stressor score, $p=.036$, yet within the health or work contexts significant correlations are absent suggesting lack of preferential strategies within the latter two areas of recent stress. In contrast, individuals showing scale (2) avoidant tendencies tend to show consistent emotional-focused preferences in coping with stressors pertaining to health, work, social and overall score, $p=.015$, $p=.002$, $p=.002$ respectively. Noteworthy are consistent patterns emerging in scales (8) passive-aggressive, (C) borderline. In the stressor areas of health, work, social and composite scores, positive correlations

Figure 2

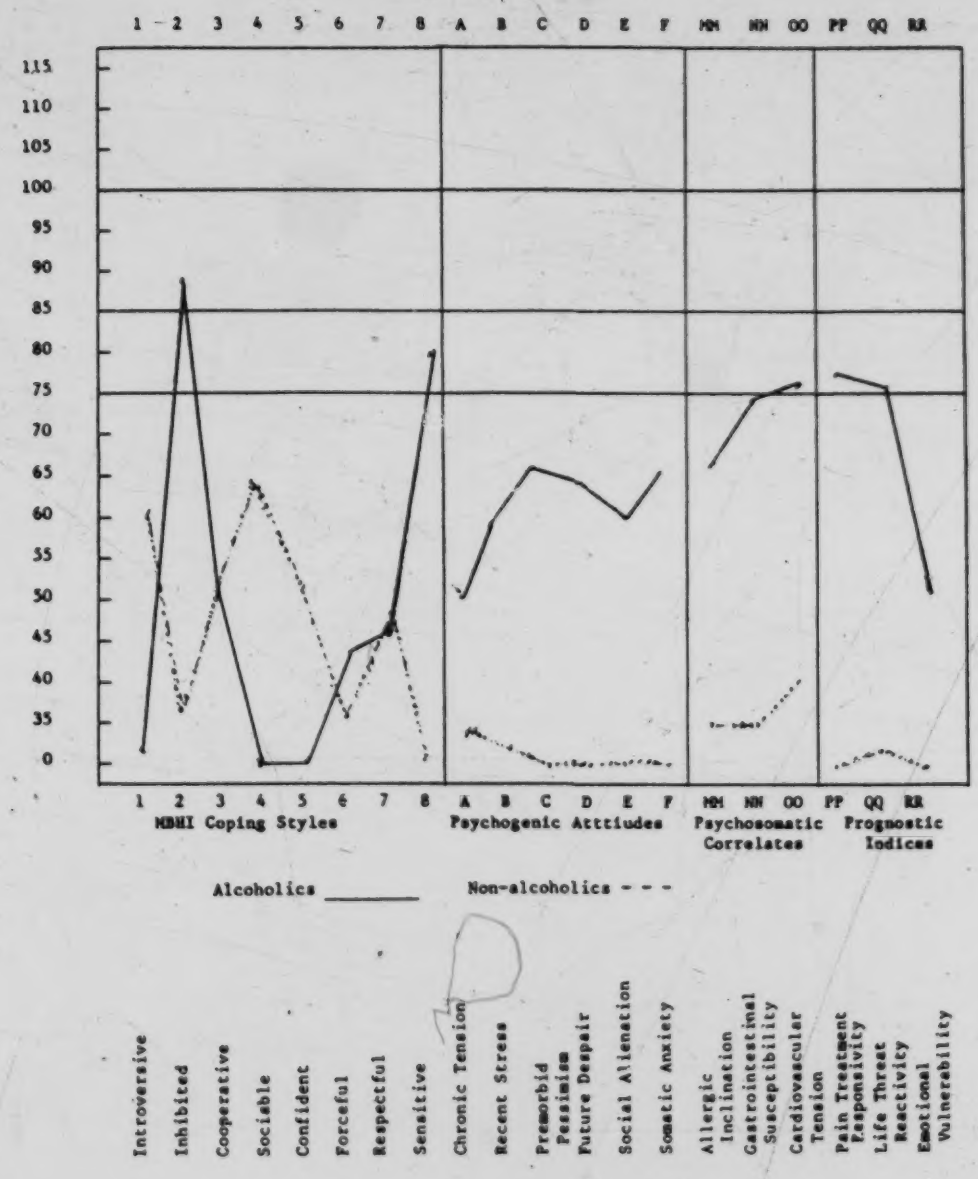

1 2 3 4 5 6 7 8 A B C D E F MM NN OO PP QQ RR
115
110
105
100
95
90
85
80
75
70
65
60
55
50
45
40
35
0
MBHI Coping Styles
Psychogenic Atttiudes
Psychosomatic Correlates
Prognostic Indices
Alcoholics
Non-alcoholics
Introversive
Inhibited
Cooperative
Sociable
Confident
Forceful
Respectful
Sensitive
Chronic Tension
Recent Stress
Premorbid Pessimism
Future Despair
Social Alienation
Somatic Anxiety
Allergic Inclination
Gastrointestinal Susceptibility
Cardiovascular Tension
Pain Treatment Responsivity
Life Threat Reactivity
Emotional Vulnerability

Table 2

Pearson Correlation Coefficents of Personality Variates and Coping Styles Amongst Alcoholic Males (N=35) p=<.05

	Coping Strategies							
	Health Stressor		Work Stressor		Social Stressor		Composite Stressors	
Personality Variables	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r
MCMI - Axis II								
1)						.38 p.012		.31 p.036
2)		.37 p.015		.48 p.002		.53 p.001		.48 p.002
3)				.34 p.023		.31 p.035		.32 p.032
4)	.35 p.020	.33 p.028					.31 p.037	
5)	.39 p.010				.35 p.019		.33 p.027	
6)				.30 p.042				
7)								

Table continues . . .

Table 2 continued

Coping Strategies

Personality Variables	Health Stressor		Work Stressor		Social Stressor		Composite Stressors	
	Problem Solving	Emotional Focus	Problem Solving	Emotional Focus	Problem Solving	Emotional Focus	Problem Solving	Emotional Focus
	r	r	r	r	r	r	r	r
8)		.49		.50		.60		.56
		p.001		p.001		p.000		p.000
S)				.37		.31		.33
				p.014		p.035		p.028
C)		.39		.35		.51		.44
		p.010		p.019		p.001		p.004
P)				.36				.30
				p.016				p.042
Axis I								
A)		.38		.33		.49		.42
		p.012		p.028		p.002		p.006
H)		.36		.39		.49		.44
		p.016		p.011		p.002		p.004
N)		.48		.55		.48		.53
		p.002		p.000		p.002		p.000

Table continues . . .

Table 2 continued

	Coping Strategies							
	Health Stressor		Work Stressor		Social Stressor		Composite Stressors	
Personality Variables	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r
D)		.38		.33		.46		.41
		p.012		p.025		p.003		p.007
B)		.57		.45		.55		.55
		p.000		p.004		p.000		p.000
T)		.49		.43	.30	.40		.47
		p.001		p.005	p.038	p.008		p.002
SS)				.36		.36		.34
					p.018			p.022
CC)		.41	.36	.51		.57		.53
		p.007	p.018	p.001		p.000		p.001
PP)	.39				.51		.44	
	p.011				p.001		p.004	

Table continues . . .

Table 2 continued

	Coping Strategies							
	Health Stressor		Work Stressor		Social Stressor		Composite Stressors	
Personality Variables	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r
MBHI - Basic - Coping Styles								
1)								
2)				.58 p.000		.53 p.001		.55 p.000
3)								
4)	.45 p.003				.29 p.045		.33 p.026	
5)	.42 p.006				.38 p.013		.34 p.022	
6)	.34 p.022	.49 p.002		.49 p.001	.39 p.011	.48 p.002	.32 p.029	.52 p.001
7)								
8)		.47 p.002		.58 p.000		.57 p.000		.57 p.000

Table continues . . .

Table 2 continued

Personality Variables	Coping Strategies: Health Stressor Problem Solving r	Health Stressor Emotional Focus r	Work Stressor Problem Solving r	Work Stressor Emotional Focus r	Social Stressor Problem Solving r	Social Stressor Emotional Focus r	Composite Stressors Problem Solving r	Composite Stressors Emotional Focus r
Psychogenic Attitudes								
A)		.44		.53	.33	.54		.53
		p.004		p.000	p.028	p.000		p.001
B)		.35		.45				
		p.020		p.003				
C)		.49		.49		.55		.54
		p.001		p.002		p.000		p.000
D)		.40		.37		.40		.41
		p.009		p.015		p.008		p.007
E)		.41		.52		.49		.50
		p.007		p.001		p.002		p.001
F)		.35		.39		.45		.42
		p.025		p.011		p.064		p.006

Table continues . . .

Table 2 continued

	Coping Strategies							
	Health Stressor		Work Stressor		Social Stressor		Composite Stressors	
Personality Variables	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r
Psychosomatic Correlates								
MM)		.42		.59		.52		.54
		p.006		p.000		p.001		p.000
NN)		.44		.44		.55		.50
		p.005		p.004		p.000		p.001
OO)		.41		.56		.57		.54
		p.007		p.000		p.000		p.000
Prognostic Studies								
PP)		.49		.51		.52		.54
		p.001		p.001		p.001		p.000
QQ)		.38		.42		.46		.45
		p.011		p.006		p.003		p.003
RR)		.53		.59		.61		.61
		p.001		p.000		p.000		p.000

are exclusively evident revealing an emotional-focused bias as follows: passive-aggressive tendencies are associated with emotional-focused strategies, in health stress, p=.001; borderline tendencies are associated with emotional-focused strategies in health stress, p=.010, work stress, p.019, social stress, p=.001, and composite, p=.004. Scale (3) dependent endorsers show an emotional-focus preference in strategies in the areas of work stress, p=.023, social stress, p=.035, and composite score, p=.032. Scale (4) histrionic tendencies reveal different coping patterns in health stress, p=.020, and composite score, p=.037, which are significantly correlated with a problem-solving orientation. Similarly, scale (5) narcissistic endorsers show a problem-solving preference in the contexts of health, p=.010, social, p=.019, and composite score, p=.027. Individual endorsing scale (6) antisocial tendencies reveal one significant correlation with emotional-focused strategies employed in the context of a work stressor. Endorsers of the (P) paranoid scale show a similar preference in the area of work, p=.016 and in the composite score, p=.042. Although correlations range from r=.30, (P=.042) to r=.60, (P=.000) signifying conservative relationships, nonetheless, different coping strategy patterns are associated with different personality variates. Total consistency does not prevail within the MCMI, Axis II, personality variates. A strong preference or

orientation towards emotional-focused strategies over three stressor contexts was found. This would suggest consistency amongst the avoidant, passive-aggressive, and borderline personalities. Eight personality inclinations show various divergent patterns of coping strategies. Personality styles of the alcoholics do show a relationship to unique patterns of coping strategies.

MCMI, Axis I

The MCMI, Axis I, variables, representing more transient aspects of personality, do reveal an overall pattern that suggests strong correspondence with an emotional-focused preference in coping strategies across all stressor contexts. The significant correlations range from r=.33 (p=.028) to r=.57 (p=.000) and for the ease of the reader exceptions only will be noted. Individuals with drug abuse tendencies show a deviation in the social stress area where problem-solving strategies reveal a significant correlation, p=.038. Similarly, individuals endorsing items on the (CC) psychotic depression scale show a problem-solving coping tendency in the context of work stress, p=.018. Problem-solving strategies are also noted in the areas of health stress, p=.011, social stress, p=.001 and the composite score, p=.004, amongst individuals endorsing (PP) psychotic delusions scale.

The MCMI, Axis I, variables appeared to have more consistency in a preference toward emotional-focus strategies,

than the MCMI, Axis II variables. Furthermore, this stable versus transient personality variate distinction in tendency towards emotional-focused coping strategies is echoed in the significant correlation patterns revealed in the MBHI as presented in Table 2.

MBHI, Basic Coping Styles

Within the basic coping styles of the MBHI there are no significant correlations emerging on scales: (1) Introversive, (3) Cooperative, and (&) Respectful. Scale (2) Inhibited endorsers show the emotional-focused coping tendencies in the areas of work stress, p=.000, social stress, p=.001, and composite score, p=.000. Similarly, scale (8) Sensitive scores reveal an emotional-focused preference in health stress, p=.002, work stress, p=.000, social stress, p=.000, and composite score, p=.000. In contrast, individuals endorsing items on scale (4) sociable reveal a level of problem-solving preference in the areas of health stress, p=.003, social stress, p=.045, and composite score, p=.026.

An identical pattern is noted amongst scale (5) confident scores, that is, in health stress, p=.006, social stress, p=.013, and composite score, p=.022. An unusual pattern emerges amongst individuals endorsing scale (6) forceful items. Problem-solving strategies tendencies may be noted in health stress, p=.022, social stress, p=.011, and composite score, p=.029. As well, emotional-focused tendencies are also noted in health stress,

p=.002, work stress, p=.001, social stress, p=.002, and in composite score, p=.001.

The basic coping style scales of the MBHI, characteristically representing relatively stable personality variates, produced correlations that ranged from r=.29, (p=.045) to r=.59, (p=.000) and in general showed lack of consistency in coping strategy patterns.

In other words, individuals who tend to endorse scales measuring inhibited or sensitive coping styles are associated with moderate tendencies to endorse the use of emotional-focused (or emotional-regulating) strategies, whereas scales measuring sociable and confident styles were associated with use of problem-solving strategies.

Individuals who endorsed items predominantly on the forceful scale tended to be associated with an approximately equal utilization of both emotional-focused and problem-solving strategies. This lack of consistency was not evident in the following three sections of the MBHI which measures attitudes and psychosomatic tendencies.

MBHI, Attitudes, Correlates and Indices

On the MBHI, Psychogenic Attitudes, Psychosomatic Correlates, and Prognostic Indices scales, a pattern of significant correlations suggest tendencies or preferences toward emotional-focused strategies. Two minor exceptions pertain to

attitudes concerning long-term and recent stress. Individuals endorsing long-term or chronic stress revealed a moderate association in use of problem-solving strategies in resolving stress in the social stress context. The recent stress scorers showed a lack of preference in both the social stress context and in the composite score. In general, transient emotional dispositions which are linked to attitudes and personal perceptions of the individual tend to be associated with endorsing use of emotional-focused strategies.

Both the MCMI, Axis II, and the MBHI, Basic Coping Styles reveal that different personality scales are related to different patterns of coping strategies. In turn, three Basic Coping Styles are characteristically associated with more relatively stable personality dimensions. More transient personality aspects revealed in the MCMI, Axis I, and the MBHI, Psychogenic Attitudes, Psychosomatic correlates, and Prognostic indices scales are related to use of emotional-focused coping strategies.

Prototypes

The next level of analysis pertained to identification of certain prototypes previously encountered in the literature. Using the MCMI, Axis II, scales, a criteria was employed as follows: base rates equal to or greater than 84 denotes prototype classification, with priority allocated to longer-term personality dimensions represented by (S) schizotypal, (C)

borderline, and (P) paranoid scales. Alcoholic prototypes derived from the MCMI scales are presented in Table 3. A total of 31 alcoholics were classified according to the previously mentioned criteria. Out of the six groups identified five groups were selected for further analysis of coping strategies, which excluded the narcissistic group representing two alcoholic males. Table 4 reveals a summary of the means and standard deviations of the coping strategies indicated by the five groups of prototypes. A one-way analysis of variance was computed to identify mean differences between the groups as presented in Table 5. In a review of the results, coping strategies amongst the 5 groups revealed significant mean differences within the social stress context, in emotional-focused coping, $F=3.998$, $p=.013$. The borderline, avoidant, and passive-aggressive groups revealed means greater than the means of the schizotypal and the dependent groups. No other meaningful differences emerged between the three stressor contexts by group classification. Grouping the alcoholics into smaller prototyptype classifications did not contribute greatly to further clinical or statistical information.

In summary, the alcoholic males showed significant distinction in the personality variables measured by the MCMI and the MBHI. Stable, versus transient, aspects of personality confirmed unique patterns of coping strategies which are related

Table 3

Alcoholic Prototypes derived from MCMI Personality Scales (N=31) (BR>84)

		N	%
MCMI Axis II Variates			
2)	Avoidant	7	23
3)	Dependent	5	16
5)	Narcissistic	2	6
8)	Passive-Aggressive	6	19
S)	Schizotypal	3	10
C)	Borderline	8	26

Table 4

Summary of Means and Standard Deviations of Coping Strategies with 5 Alcoholic Prototypes

	Coping Strategies						
	Health Stressors		Work Stressors		Social Stressors		
	Problem Solving	Emotional Focus	Problem Solving	Emotional Focus	Problem Solving	Emotional Focus	
	$\bar{X}$ (SD)	$\bar{X}$ (SD)	$\bar{X}$ (SD)	$\bar{X}$ (SD)	$\bar{X}$ (SD)	$\bar{X}$ (SD)	
1) Borderline (N=8)	42.00 (16.39)	52.63 (10.88)	42.38 (15.73)	47.63 (13.28)	43.88 (15.32)	53.38 (10.49)	*
2) Schizotypal (N=3)	34.00 (13.08)	37.67 (8.62)	36.00 (14.11)	34.67 (6.43)	34.00 (12.49)	35.00 (8.96)	*
3) Dependent (N=4)	47.60 (11.33)	37.80 (9.76)	47.60 (17.98)	28.60 (10.07)	48.20 (11.28)	35.80 (8.96)	*
4) Avoidant (N=7)	50.43 (8.83)	53.14 (11.84)	52.29 (8.88)	48.00 (13.70)	49.14 (10.09)	53.71 (9.00)	*
5) Passive-Aggressive (N=6)	39.50 (14.35)	54.50 (15.93)	44.67 (16.32)	42.50 (12.49)	40.83 (15.74)	50.17 (13.23)	*

* $p=<.05$ =

1, 4, 5 > 2, 3

Table 5

One-Way Anova for Coping Strategies of Alcoholic Prototypes (N=29)

Health Stressor: Problem-Solving

Source	df	SS	MS	F
Between Groups	4	804.137	201.034	1.140 (.362)
Within Groups	24	4232.414	176.351	
Total	28	5036.552		

Health Stressor: Emotional Focus

Source	df	SS	MS	F
Between Groups	4	1419.267	354.817	2.456 (.073)
Within Groups	24	3467.699	144.488	
Total	28	4886.966		

Work Stressor: Problem-Solving

Source	df	SS	MS	F
Between Groups	4	697.405	174.351	.800 (.537)
Within Groups	24	5227.837	217.827	
Total	28	5925.241		

Table continues . . .

Table 5 continued

Work Stressor: Emotional Focus

Source	df	SS	MS	F
Between Groups	4	1565.724	391.431	2.590 (.062)
Within Groups	24	3627.242	151.135	
Total	28	5192.966		

Social Stressor: Problem-Solving

Source	df	SS	MS	F
Between Groups	4	641.945	157.986	.879 (.491)
Within Groups	24	4313.366	179.724	
Total	28	4945.310		

Social Stressor: Emotional Focus

Source	df	SS	MS	F
Between Groups	4	1738.511	434.628	3.998 (.013)*
Within Groups	24	2608.937	108.706	
Total	28	4347.448		

* $p<.05$

to distinct personality styles. Thus, the hypothesis derived support. Indeed, the personality style of the alcoholic is related to their coping strategy pattern.

Hypothesis 2

Level of perceived social support will be related to frequency of appraised coping strategies.

In reviewing the results presented in Table 6, there are no significant correlations associated with level of social support. Logically-derived associated demographic variables are also presented in Table 6 and reveal significant correlations between coping strategies and social support. Affirmation of a confidant is negatively related to use of emotional-focused coping strategies in the following contexts: health stress, r=-.39, p=.011; work stress, r=-.45, p=.003; social stress, r=-.42, p=.006; and composite score, r=-.45, p=.004.

In reasoning that level of support may be influenced by relationships with associated demographic variables, correlations were examined with the following: social support, marital status, parental support and age. Table 7 indicates several moderately significant relationships which emerged. Level of support is related to: social support, r=.47, p=.002, marital status, r=.43, p=.005; parental support, r=.36, p=.016, and age r=.38, p=.013. Individuals perceiving higher levels of social support are in general, associated with affirmation of confidant, being married, feeling positive in regards to parental support, and

being older in age. The converse of these positive relationships is equally possible and may tend to confound the level of social support in relation to coping strategies.

In summary, no correlations of statistical significance are noted between level of social support and coping strategies. Consequently, no support is evident for this hypothesis.

Hypothesis 3

Level of career satisfaction will be related to appraised coping strategies.

The results presented in Table 8 reveal no significant correlations between career satisfaction and coping strategies, which provide no support for this hypothesis. Associated demographic variables such as age, education, and health were assumed reasonable alternatives to investigate and are presented in Table 8. Noteworthy, are significant correlations between age and coping strategies in the following contexts: health stress, r=-.29, p=.044; work stress, r=-.38, p=.013; social stress, r=-.38, p=.013; and composite score, r=.31, p=.036. Increasing age levels are related to decreasing use of emotional focused coping strategies. In addition, health level reveals an interest in negative correlation within the work stressor context, r=-.30, p=.042. This suggests that relatively poor physical health is related to greater use of problem-solving strategies in the work place.

Table 6

Correlations of Social Support, Level of Social Support, Marital Status, and Parental Support with Sources of Coping Strategies Amongst Alcoholic Couples (N=35)

	Health		Work		Social		Composite	
	Problem Solving r	Emotional Solving r	Problem Solving r	Emotional Solving r	Problem Solving r	Emotional Solving r	Problem Solving r	Emotional Solving r
Social Support	.11 p=.257	-.39 p=.011*	.14 p=.211	-.45 p=.003*	.20 p=.127	-.42 p=.006*	.16 p=.179	-.45 p=.004*
Level of Support	.11 p=.270	-.18 p=.155	.13 p=.232	-.21 p=.112	.20 p=.123	-.13 p=.222	.15 p=.188	-.19 p=.144
Marital Status	.02 p=.460	.11 p=.271	.12 p=.241	-.08 p=.322	.23 p=.092	.06 p=.361	.13 p=.228	.03 p=.432
Parent Support	.02 p=.463	-.20 p=.123	-.07 p=.336	-.08 p=.321	.10 p=.292	-.12 p=.252	.01 p=.476	-.14 p=.210

*p=<.05

Table 7

Correlations of Social Support, Level of Support, Marital Status, Parental Support and Age Level Amongst Male Alcoholics (N=35)

	Level of Support r	Marital Status r	Parental Support r	Age Level r
Social Support	.47 p=.002*	.16 p=.179	.32 p=.032*	.30 p=.040*
Level of Support		.43 p=.005*	.36 p=.016*	.38 p=.013*
Marital Status			-.01 p=.488	.28 p=.051
Parental Support				.12 p=.247

*p=<.05

Table 8

Correlations of Career Satisfaction, Age, Education and Health with Scores of Coping Strategies Amongst Alcoholic Males (N=35)

	Health		Work		Social		Composite	
	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r	Problem Solving r	Emotional Focus r
Career Satisfaction	.19 p=.139	-.19 p=.140	.10 p=.293	.04 p=.421	.27 p=.057	-.10 p=.282	.20 p=.131	-.09 p=.306
Age Level	.35 p=.042*	-.29 p=.044*	.23 p=.089	-.38 p=.013*	.29 p=.045	-.20 p=.125	.29 p=.045	-.31 p=.036*
Education Level	.05 p=.399	.20 p=.120	.18 p=.154	-.06 p=.377	.02 p=.454	.07 p=.352	.09 p=.305	.08 p=.333
Health Level	-.04 p=.402	.08 p=.330	-.30 p=.042*	.14 p=.220	-.07 p=.348	-.07 p=.345	.15 p=.196	.10 p=.284

*p=<.05

In Table 9, career satisfaction is shown to relate to the following associated demographic variables: age, r=.38, p=.013, and level of support, r=.30, p=.039. One may note that age level, education level, and health level reveal no significant relationship. This may mean there is a lack of direct influence on coping strategies by career satisfaction, amongst the alcoholic men.

In summary, no significant correlations between career satisfaction and coping strategies emerged to provide support for hypothesis 3.

Hypothesis 4

Appraised coping strategies of alcoholics will differ from the appraised coping strategies of non-alcoholics both in terms of frequency and in problem-solving efforts.

In reviewing the results presented on Table 10, the means, standard deviations, and ranges of all coping strategy measures by group are presented. In contrast to the non-alcoholics, the alcoholics as a group reveal a trend of slight consistency in means throughout each measure of coping strategies. In addition they tend to show a slightly broader range of scores (and subsequently) slightly increasing deviation throughout all measures. That is, the form of distributions for the alcoholics in general tend to be platykurtic whereas the non-alcoholics tend to be mesokurtic. This suggests less homogenic tendencies in coping strategies amongst the latter group.

Table 9

Correlations of Career Satisfaction, Age Level, Education Level, Health Level, and Level of Support Amongst Alcoholic Males (N=35)

	Age Level r	Education Level r	Health Level r	Level of Support r
Career	.21	-.11	.26	.30
Satisfaction	p=.108	p=.274	p=.064	p=.039*
Age		.08	-.34	.38
Level		p=.326	p=.024*	p=.013*
Education			-.08	.10
Level			p=.323	p=.281
Health				.02
Level				p=.446

*p=<.05

Table 10

Means, Standard Deviations and Ranges of Coping Strategies in Stress, Contexts of Health, Work, Social, and Composite Score Contesting Alcoholics (N=35) to Non-alcoholics (N=35)

Coping with Health Stress	x=44.37, SD=13.35	x=36.51, SD=11.30
(Problem-Solving Focus)	(R=21-71)	(R=13-61)
Coping with Work Stress	x=46.86, SD=13.18	x=24.31, SD=10.28
(Problem-Solving Focus)	(R=25-69)	(R=7-43)
(Emotional-Focus)	x=40.11, SD=13.41	x=38.86, SD=10.81
	(R=13-69)	(R=19-61)
Coping with Social Stress	x=43-86, SD=12.82	x=39.20, SD=11.83
(Problem-Solving Focus)	(R=20-69)	(R=21-68)
(Emotional-Focus)	x=45.26, SD=12.89	x=23.03, SD=12.11
	(R=25-67)	(R=7-48)
Composite Score	x=44.31, SD=12.59	x=38.19, SD=10.81
(Problem-Solving)	(R=17.67-70.33)	(R=17.67-63.33)
(Emotional-Focus)	x=44.08, SD=12.42	x=23.48, SD=10.35
	(R=24.00-66.67)	(R=7.00-41.67)

Table 11 presents the results of a two-sample Hotelling T^2 test on the coping strategy means in the areas of Health stress, Work stress, and Social stress. The groups reveal significant differences as follows: Health stress, emotional-focus, F=9.832, p=.000; Work stress, emotional-focus, F=5.366, p=.000; Social stress, emotional-focus, F=8.534, p=.000. The results suggest that although the two groups do not differ in means of problem-solving coping throughout stress contexts, the alcoholics tend to reveal a preference for emotional-focus coping across stress areas. That is, no significant difference emerges in regards to problem-solving tendencies between the alcoholics and the non-alcoholics. Figure 3 displays the coping strategy patterns concisely.

When a T-test was calculated for the composite mean scores, which encompasses the three contexts of stress, a different picture emerges. Table 12 reveals significant t values between the means of the groups in both problem-solving and emotional focus coping strategies, t=2.18, p=.033; and t=7.54, p=.000, respectively. What this test reveals is that overall frequency means are in fact different for the two groups when the stress categories are collapsed. This allows the slight mean-consistency trend, previously discussed in the results of Table 10, to be taken into account. In considering the total frequency and overall problem-solving efforts of the alcoholics

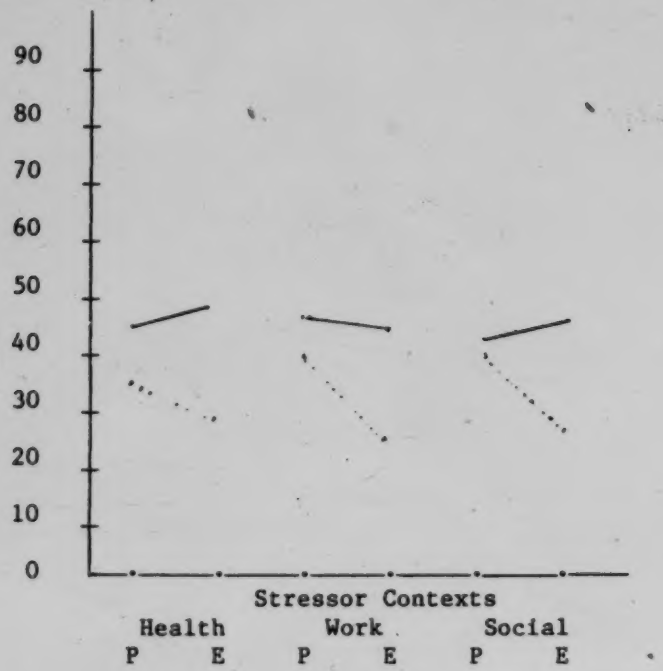
Table 11

Two-Sample Hotelling T^2 Test of Coping Strategies for Alcoholic and Non-Alcoholic Groups (N=70)

Variable	T^2	F	df	df	Probability =<.05*
Health Stress					
Problem-Solving	7.067	1.091	6	63	0.3777
Emotional Focus	63.671	9.832	6	63	0.000 *
Work Stress					
Problem-Solving	3.753	0.580	6	63	0.745
Emotional Focus	34.749	5.366	6	63	0.000 *
Social Stress					
Problem-Solving	2.493	0.385	6	63	0.886
Emotional Focus	55.265	8.534	6	63	0.000 *

Figure 3

Coping Strategy Means



Alcoholics _____

Non-Alcoholics - - - - -

P = Problem Solving

E = Emotional Focus

Table 12

T-Test for Composite Mean Score of Problem-Solving and Emotional-Focus Strategies Between Alcohlics (N=35) and Non-Alcoholics (N=35)

Composite Coping Strategies	T-value	df	Probability = <.05*
Problem-Solving	2.18	68	.033 *
Emotional Focus	7.54	68	.000 *

in contrast to the non-alcoholics, the results ultimately provide support for hypothesis 4. That is, coping strategies of alcoholics differ from coping strategies of non-alcoholics in terms of frequency and in problem-solving efforts.

B. Subject Characteristics

The characteristics of the male subjects are presented in Table 13 by group affiliation and are represented by range (R), percentages, and frequencies. The variables depicting social and demographic information are followed by scores derived from both groups on the Short Michigan Alcohol Screening Test (SMAST).

Age

In terms of age, 49% of the alcoholics ranged in age from 21 years to 35 years in slight contrast to 54% of the non-alcoholics who ranged in age similarly from 21 years to 35 years. The somewhat older group amongst the alcoholics ranged in age from 36 years to 60 years representing 51% of the total alcoholic group, while the non-alcoholics ranged in age from 36 years to 57 years representing 46% of their respective group.

Occupation

The rank order of occupations was derived from a Canadian Occupational Prestige Index (Eichler, 1976). Amongst the alcoholics 74% ranked between scores of 31 to 64. In comparison, 71% of the non-alcoholics ranked between 23 and 64. Blue collar level of jobs denote training in various skilled and semi-skilled capacities. In addition, 26% of the alcoholics scored rank order

between 65 to 92. White collar level of careers require a specialized, post-secondary education, training program. The non-alcoholics at 29% scored rank order between 65 and 93 for this same level.

Education

The educational background for both groups show a slight bias towards educational resources amongst the non-alcoholic group. In terms of post-secondary levels, the alcoholics reveal a 34% identification in contrast to 48% of the non-alcoholic group. At the grade 12 level, the alcoholics at 26% similarly contrast to 46% of the non-alcoholics. Alcoholics with less than a grade 12 level of education represent 40% of their groups whereas 6% of the non-alcoholic groups show similar identity.

Marital Status

Sharp contrasts are also observed within marital status between the groups. Relatively few alcoholics, at 31%, affirm being married in comparison with 82% at the non-alcoholics. Subsequently 46% of the alcoholics are single in contrast to 9% of the non-alcoholics. Similarly, 23% of the alcoholics are divorced whereas 9% of the non-alcoholics show a parallel identification.

Career Satisfaction

In regards to career satisfaction, 14% of the alcoholics report excellent career satisfaction in contrast to 37% of the non-alcoholics. Furthermore, 51% of the alcoholics report good

career satisfaction while 43% of the non-alcoholics reveal similar correspondence. Relatively minor numbers of both groups report a fair or poor experience in their careers. That is, the alcoholics representing lack of career satisfaction constitute 35% of their group while 20% of the non-alcoholics are similarly disposed.

Social Support

In the area of social support connoting availability of a confidant, 71% of the alcoholics reveal confirmation of this support whereas 91% of the non-alcoholics correspondingly agree. Those denying confidant availability constitute 29% of the alcoholics in comparison with 9% of their non-alcoholic counterparts.

Level of Social Support

In appraising current level of social support, 12% of the alcoholics in contrast with 34% of the non-alcoholics report an excellent level of support. Those reporting a moderate good level of social support are represented by 31% of the alcoholics in comparison with 57% of the alcoholics report shared perceptions while 9% of the non-alcoholics reveal similar inclinations.

Father's Drinking Pattern

In terms of father's drinking pattern, 11% of the alcoholics relate to a father who did not drink alcohol while 6% of the

non-alcoholics agree with a similar background. Amongst those identifying fathers who were inclined to drink socially, 49% of the alcoholics contrast to 74% of the non-alcoholics. Heavy paternal drinking patterns were reported by 11% of those alcoholics in comparison with 20% of the non-alcoholics. Amongst those reporting perceived alcoholic tendencies within their father's drinking pattern, 29% of the alcoholics endorsed this observation whereas 10% of the non-alcoholics shared similar perceptions.

Parental Support

In regards to parental support characteristically provided through modeling of problem-solving coping strategies, 31% of the alcoholics in contrast to 49% of the non-alcoholics affirmed perceived experience as most of the time. Amongst those endorsing frequent parental support in this regard, 20% of the alcoholics showed slight correspondence with 14% of their non-alcoholic counterparts. Similarly slight correspondence was noted amongst those endorsing the seldom experienced parent support level. That is, 37% of the alcoholics and 34% of the non-alcoholics were similarly represented at this level. Amongst those indicating never experiencing parental support through problem-solving oriented coping skills, 12% of the alcoholics compared with a minor 3% representation amongst the non-alcoholics.

Major Stress

Amongst those individuals affirming lack of recent major stress in their lifestyles, 26% of the alcoholics revealed a sharp contrast to 60% of the non-alcoholics. On the other hand, 74% of the alcoholics in comparison with 40% of the nonalcoholics reported experiencing a recent major stressor such as death, divorce, loss of employment, or loss of a friend in their lives.

Degree of Stress

In considering the degree of experienced difficulty with the major stressor, 76% of the alcoholics appraised the stressor as being extremely difficult, whereas 23% of the non-alcoholics shared a similar level of challenge. Amongst those endorsing a moderate level of difficulty in coping with their major stressor, 12% of the alcoholics contrasted sharply to 62% of the non-alcoholics. Revealing slight correspondence in experiencing their respective stressors as mildly difficult, 12% of the alcoholics compared similarly with 15% of the non-alcoholics.

Physical Health

In evaluating current level of physical health, a minor 3% of the alcoholics in contrast to 21% of their non-alcoholic counterparts affirmed their health as excellent. Reporting a perceived good level of physical health, a preponderance of 66% of the alcoholics in correspondence with 76% of the non-alcoholics affirmed a similar level of health. In reporting a fair level of physical health 17% of the alcoholics contrasted

slightly with 3% of their non-alcoholic counterparts. Non-alcoholics reported no poor level of physical in contrast to 14% of the alcoholics who appraised their current level of health as being poor.

Alcoholic Tendencies

In regards to alcoholic tendencies, score frequencies for both groups are presented in Table 13. The Short Michigan Alcohol Screening Test (SMAST) (Selzer, Vinokir, & Van-Rooijen, 1975) employs a criterion score of five to discriminate alcoholic tendencies. While 100% of the non-alcoholics revealed scores ranging from zero to three, 43% of the alcoholics also scored less than the criterion score of five. Since the SMAST consists of overt statements in regards to alcohol abuse, it appears reasonable to assume that the relatively more subtle items representing history of alcohol abuse on the Millon Clinical Multiaxial Inventory (MCMI) (Millon, 1983) provided a more robust distinction amongst the subjects participating in the current study.

Significant Social Differences

Significant differences between the alcoholics and non-alcoholics on social and demographic variables were identified and concisely represented on Table 14.

The alcoholics tended in general to experience poor to fair levels of physical health. In contrast, non-alcoholics almost

Table 13

Characteristics of the 70 Male Subjects by Percentiles

	Alcoholic	Non-Alcoholic
Social and Demographic		
Age	(R=21-60)	(R=21-57)
<35 years	49% (17)	54% (19)
>36 years	51% (18)	46% (16)
Rank Order of Occupational Prestige	(R=31-92)	(R=23-93)
Blue Collar/Semi-Skilled and Skilled	74% (26)	71% (25)
White Collar/ Semi-Professional and Professional	26% (9)	29% (10)
Education	(R=3-1)	
Post Secondary	34% (12)	48% (17)
Grade 12	26% (9)	46% (16)
Less than Grade 12	40% (14)	6% (2)
Marital Status	(R=3-1)	
Married	31% (11)	82% (29)
Single	46% (16)	9% (3)
Divorced/Separation	23% (8)	9% (3)

Table continues . . .

Table 13 continued

	Alcoholic	Non-Alcoholic
Social and Demographic		
Career Satisfaction	(R=4-1)	(R=21-57)
Excellent	14% (5)	37% (13)
Good	51% (18)	43% (15)
Fair	26% (9)	17% (6)
Poor	9% (3)	3% (1)
Social Support of Confidant	(R=2-1)	
Yes	71% (25)	91% (32)
No	29% (10)	9% (3)
Level of Social Support	(R=4-1)	
Excellent	12% (4)	34% (12)
Good	31% (11)	57% (20)
Fair	40% (14)	9% (3)
Poor	17% (6)	
Father's Drinking Pattern	(R=1-4)	
Not at all	11% (4)	6% (2)
Socially	49% (17)	74% (26)
Heavily	11% (4)	20% (9)
Likely alcoholic	29% (10)	10% (4)
Parental Support	(R=4-1)	
Most of the time	31% (11)	49% (17)
Frequently	20% (7)	14% (5)
Seldom	37% (13)	34% (12)
Never	12% (4)	3% (1)

Table continues . . .

Table 13 continued

	Alcoholic	Non-Alcoholic
Social and Demographic		
Recent Major Stressor	(R=1-2)	
No	26% (9)	60% (21)
Yes	74% (26)	40% (14)
Degree of Experienced Difficulty with Stressor	(R=3-1)	
Extremely difficult	76% (20)	23% (3)
Moderately difficult	12% (3)	62% (8)
Mildly difficult	12% (3)	15% (2)
Current Level of Physical Health	(R=4-1)	
Excellent	3% (1)	21% (7)
Good	66% (23)	76% (26)
Fair	17% (6)	3% (1)
Poor	14% (5)	
Short Michigan Alcohol Screening Test		
(Criterion Score = 5)	(R=0-10)	(R=0-3)
Score=0	11% (4)	88% (31)
Score=1		9% (3)
Score=2	14% (5)	
Score=3	9% (3)	3% (1)
Score=4	11% (4)	

Table continues . . .

Table 13 continued

	Alcoholic	Non-Alcoholic
Social and Demographic		
Short Michigan Alcohol Screening Test		
(Criterion Score = 5)	(R=0-10)	(R=0-3)
Score=5	9% (3)	
Score=6	9% (3)	
Score=7	11% (4)	
Score=8	9% (3)	
Score=9	11% (4)	
Score=10	6% (2)	

Table 14

Social and Demographic Variables Between Alcoholics and Non-Alcoholics (N=70)

	Health Level (1,2-Low) (3,4=High)		Education Level (1=<12) (2=12) (3=>12)			Marital Status (1=D) (2=S) (3=M)		
Alcoholics (N=35)	11	24	14	9	12	8	16	11
	31%	69%	40%	26%	34%	23%	46%	31%
Non-alcoholics (N=35)	1	33	2	16	17	3	3	29
	3%	97%	6%	46%	48%	9%	9%	82%
	x^2=7.86/df 1		x^2=11.82/df 2			x^2=19.28/df 2		
	p=.005*		p=.003*			p=.000*		

	Social Support Levels (1=Poor)(2=Fair)(3=Good)(4=Excellent)				Stress (1=No)(2=Yes)		Degree of Stress (1=Mild)(2+Moderate)(3=Extreme)		
Alcoholics	6	14	11	4	9	26	3	3	20 (N=26)
(N=35)	17%	40%	31%	12%	26%	74%	12%	12%	76%
Non-Alcoholics	0	3	20	12	21	14	2	8	3 (N=14)
(N=35)	0%	9%	57%	34%	60%	40%	15%	62%	23%
	x^2=19.73/df 3				x^2=7.06/df 1		x^2=12.04/df 2		
	p=.000*				p=.008*		p=.002*		

*p=<.05

consistently reported good to excellent current levels of health, $x^2=7.86/1$, $p=.005$.

Educational levels revealed notable differences between the two groups reflecting a lower educational background amongst the alcoholics. The non-alcoholics reflected a slight bias towards post-secondary education, $x^2=11.82/2$, $p=.003$.

Concerning marital status, the majority of the non-alcoholics tended to be married whereas approximately two thirds of the alcoholics tended to be single or divorced, $x^2=19.28/2$, $p=.000$.

Level of social support also revealed noteworthy differences between the groups. Approximately one half of the alcoholics appraised their social network as good to excellent. In contrast, the majority of the non-alcoholics shared corresponding perceptions, $x^2=19.73/3$, $p=.000$.

Affirmation of a recent major stressor also revealed a group polarity. The majority of the alcoholics tended to confirm experiencing a substantial loss, while relatively few of the non-alcoholics were so inclined, $x^2=7.06/1$, $p=.008$.

In reference to degree of stress experienced in attempting to cope with the previously mentioned major stressor, the majority of alcoholics tended to endorse extreme difficulty. On the other hand, the non-alcoholics showed an inclination to endorse moderate difficulty as representative of their experience with a major stressor, $x^2=12.04/2$, $p=.002$.

Table 15 reveals alcohol abuse tendencies as measured by the SMAST, between groups. As anticipated the mean of the non-alcoholics contrasts sharply with the alcoholics and reveals a significant t-value indicating alcohol-abuse tendencies amongst the alcoholics, t=9.20/68, p=.000.

In brief, subject characteristics were presented by group affiliation. Results indicated that remarkably few social variables revealed statistically-significant group distinction. Included within the noteworthy category are the following variables: physical health, level of education, marital status, recent major stress, degree of stress experienced, and alcohol abuse tendencies as measured by the SMAST (Selzer, Vinokir, & Van -Rooijen, 1975).

Table 15

Short Michigan Alcohol Screening Test Score Means, Standard Deviations, and t-value

Alcoholic (N=35)	Non-alcoholics (N=35)			
Mean (Sd)	(Mean (SD)	T-value	df	Probability
5.03 (3.07)	0.17 (0.57)	9.20	68	.000 *

*p<.05

Summary

To summarize the results reported in this chapter, statistical significance provided support for hypotheses 1 and 4,

while hypotheses 2 and 3 were not confirmed. Hypothesis 1 was that alcoholics in general reveal several personality styles that are not evident amongst their non-alcoholic counterparts. Furthermore these personality variables are related to distinct coping strategy patterns. Hypothesis 4 predicted that in terms of overall frequency and problem-solving efforts, the alcoholics would differ from non-alcoholics. No support emerged for a relationship between level of social support and coping strategies (hypothesis 2) and for a relationship between career satisfaction and coping strategies (hypothesis 3). In regards to subject characteristics, differences between the alcoholics and non-alcoholics were found on the following social and demographic variables: physical health, education, major stressor, degree of stress, and alcohol abuse tendencies. Alcoholics as a group tended to be represented by lower levels of physical health and educational attainment, in addition to being single or divorced. As well, the alcoholics tended to have experienced recent major stressors and were inclined to endorse substantial difficulty in attempts at resolution. Alcohol abuse tendencies were also more notable amongst the alcoholic group in contrast to the non-alcoholic group.

Chapter V

Discussion

Possible reasons why the results eventuated in the actual findings are presented. Some discussion of the limitations of the project is offered. To conclude, research directions and clinical implications are overviewed.

Hypothesis 1 Discussion

The results of the present study reveal that personality styles of alcoholics are distinguishable from non-alcoholics. Moreover such styles can be identified as distinct prototypes previously recognized in the literature, and are related to different patterns of coping strategies.

Some personality differences emerged as contrasts for the alcoholic subjects to the non-alcoholic subjects. The alcoholics tended to distinguish themselves on the following MCMI, Axis II, personality scales: schizoid, avoidant, passive-aggressive, schizotypal and borderline. In regards to pattern of symptoms, the alcoholics showed contrast to the non-alcoholics on the following MCMI, Axis I, scales: anxiety, dysthymia, alcohol abuse, psychotic thinking, and psychotic depression. The overall alcoholic group profile suggests an individual with a marked history of alcohol abuse:

(a) is currently experiencing substantial levels of dysphoria and anxiety,

(b) likely reports a variety of physical discomforts,

(c) at times manifests incongruous thinking and behavior notably in conjunction with ruminations concerning future despair

(d) has an essentially alienated self-image

(e) exhibits long-term patterns of dependency conflicts

(f) displays passive-aggressive tendencies in relating to others,

(g) reveals a current inclination to withdraw from social interaction

(h) avoids self-introspection and acknowledgement of latent anger.

The danger in assuming group affiliation with the hypothetical profile is in missed identification of the sometimes small, but by no means clinically insignificant differences and resources essential in planning individual treatment programs. Consequentially, the individual personality scales were scrutinized for potential relationships with unique coping strategy patterns.

MCMI: Axis II

Individuals inclined to endorse items on the schizoid scale and who show marked elevations regarding this personality style tend to reveal a level of flexibility in coping with stressors in contexts of health and work. Social stressors appear to elicit an inclination of preference towards use of emotional regulating (or emotional-focused) coping strategies. These socially-peripheral (or private) individuals who commonly harbor a

complacent self-image, appear to be skilled in the use of balance of both problem-solving and emotional-focused coping strategies in stressor areas that may be resolved with little intervention or interaction required from others. In terms of social or family stress, these individuals may be contributing to intensification of family or social problems. By retreating into emotional regulating activities such as avoidance or distancing, they do not use negotiation and confrontational skills that may provide conflict resolution. In such a case, social skills training or family counselling may be beneficial and draw upon skills or strategies acquired in areas other than the social milieu (i.e., an identified resource). The task is to promote generalization of flexibility across stressors encountered within their lifestyle.

The next three scales share a personality commonality. The alcoholics are inclined to reveal corresponding preference towards emotional-focused coping strategies throughout stressor contexts. The notable scales include: avoidant, passive-aggressive, and the more severe (or well-learned cognitive and behavioral inclinations) borderline personality. The common personality core shared by endorsers of these three scales is an alienated, discontented, tenuous identity or low self-esteem. In addition, these individuals tend to distrust others and are frequently emotionally distressed and show difficulty in appropriate emotional expression and social assertion. The borderline and the passive-aggressive are

frequently more volatile and angry. They tend to focus energy inward, ruminating instead of processing information from their respective environments. Establishing trust is a challenge with these individuals. However, trust can build with time and patience and be enhanced through individual counselling. Programs directed towards building self-esteem, and the acquisition of assertiveness and self-relaxation skills tends to promote restoration of control. Group therapy oriented towards self-insight provides an opportunity to understand attitudes and beliefs that can perpetuate vicious cycles of self-defeating behavior for the alcoholic.

Depending on the level of potential organic impairment, various levels of cognitive resources need also to be considered in recommendations for program readiness. Compulsive scale endorsers scoring within a moderate range of elevation frequently tends to reflect a level of self-discipline and ability to organize and attend to details. In fact, the compulsive scale endorsers revealed a totally flexible pattern throughout all areas of appraised stress which suggests substantial resources for these individuals who scored within a moderate, rather than a marked elevated pattern. In terms of treatment programs, compulsive style individuals typically adhere to program schedules and respond well to cognitive-oriented therapy. With moderate scale elevation, these individuals tend to maintain

positive self-esteem. Characteristically they view themselves as conscientious. In the current study, this was clearly reflected in the flexible coping strategies.

In contrast to the compulsive style, the dependent scale endorsers commonly view themselves as weak and ineffectual. Low self-esteem and lack of assertiveness is likely reflected in the emotional-focus tendencies observed in their appraised coping strategies. Perhaps the health stress anomaly in an otherwise consistent pattern of emotional regulating coping preference may relate to receiving attention and direction from health care professionals. Stress in context of health may have been appraised as a responsibility outside personal control, eliciting an acquiescent response. For these individuals programs enhancing self-esteem can be substantially beneficial. Group participation in programs oriented towards a cognitive regime tends to facilitate reduction of emotional discomfort and correspondingly, increments in levels of self-esteem.

Positive self-image is a commonality shared by individuals endorsing the following three scales: histrionic, narcissistic, and antisocial. The histrionic style individuals tend to utilize both problem-solving coping and emotional-focused strategies in resolving both health and work all three contexts of stressors. The narcissistic style shows a slight preference for problem-solving strategies in the areas of health and social

stress. The antisocial style reveals an emotional-focused orientation in coping with stressors encountered in the work place, but also reveals resources in flexible employment of strategies in context of health and social stressors. In general, these individuals are usually adept in social communications and typically feel comfortable with group programs. While most cognitive-based treatment programs would tend to facilitate in reducing current levels of emotional-discomfort, relapse prevention programs offered by community resources outside the hospital setting (such as AADAC) would tend to facilitate acquisition of self-control.

The schizotypal and paranoid scales reflect longer-term personality dimensions and just as with the borderline personality style, may be interpreted as well-learned patterns of cognitive and behavioral inclinations that frequently require longer-term treatment programs. In terms of coping with health stressors, both scales reflect a level of flexibility, denoted by lack of strategy preference. Perhaps, not unlike the dependent style individuals, an explanation might be related to a perception of lack of control and corresponding responsibility when encountering health-related stressors. The schizotypal scale endorsers reveal a preference for emotional-focused coping within the work and social contexts of stress. This is logical since others tend to perceive these individuals as eccentric,

secretive, and difficult to communicate with. The paranoid scale endorsers, not unlike the antisocial style individuals, reveal emotional-focused coping strategies when encountering work stressors. In contrast to the schizotypal style individuals, who commonly experience an estranged sense of self, or low self-esteem, the paranoid scale endorsers in correspondence with the antisocial individuals maintain a positive sense of self. While the paranoid individuals may be troublesome in the work place by their tendency to be viligant and somewhat abrasive, the competitive antisocial scale endorsers frequently appear as quarrelsome, particularly in regards to authority. In occupational settings which require a team effort, it appears likely that both the antisocial individuals and those with paranoid styles would tend to perceive chronic rather than acute stressors. These perceptions would elicit emotional-focused coping, perhaps in order to retain employment. In brief, clinically-significant information was derived from the MCMI, Axis II, scales as they related to unique patterns of coping strategies, that would not have been identified by interpreting the mean profile of the alcoholic group.

MCMI: Axis I

The MCMI, Axis I, personality variates tend to represent symptoms currently experienced by the individuals. Noteworthy is the level of consistency in the tendency towards emotional-regulating coping strategies. To place this tendency

in perspective, it is important to note that the alcoholics as a group differed in a statistically-significant manner from their non-alcoholic counterparts basically on the following scales: anxiety, dysthymia, alcohol abuse, psychotic thinking and psychotic depression. As a group, some levels of symptoms were commonly represented by the non-alcoholic group.

MBHI

The MBHI, is a measure of basic coping styles and psychosomatic influences which are pertinent to treatment process and outcome, was created for non-psychiatric patients. Hence, it was designed with far less power to assess psychopathological tendencies when compared to the MCMI. While the MCMI has 11 personality scales representing more stable aspects of personality in comparison with the more transient dimensions of symptomatologies, the MBHI has eight (relatively stable) basic coping style scales. The alcoholics tended to be inhibited and sensitive whereas the non-alcoholics tended to reveal an inclination towards the sociable and confident styles.

In terms of the alcoholic group, those individuals endorsing scale items on the introversive, cooperative, and respectful scales showed no preference in use of either problem-solving or emotional-focused coping strategies. Individuals endorsing the inhibited scale items showed an inclination towards emotional-focused coping in the areas of work stress and social stress. These individuals tend to be easily hurt and are

cautious in relating to others, not unlike some tendencies revealed by endorsers of the MCMI avoidant scale. Unlike the avoidant scale endorsers, the inhibited style endorsers revealed no preference in appraised coping strategies. Perhaps this tendency suggests a level of confidence in the health professionals, or a level of denial in owning health problems. The sensitive scale endorsers, in correspondence with the passive-aggressive scale endorsers of the MCMI, revealed a consistent pattern of emotional-focused strategies through all stressor contexts. Characteristically, these unpredictable and frequently moody individuals represent a challenge to health care professionals. Establishing rapport and encouraging treatment adherence is not impossible with patience and vigilance for potential opportunities to establish credence and trust in treatment direction. In contrast, individuals endorsing items on the following scales are typically well-skilled in social communications facilitating initial contact with health care professionals: sociable, confident, and forceful styles. These individuals consistently revealed substantial experience in problem-solving strategies as well as experience in flexible coping. These individuals usually tend to perceive themselves as capable in coping with most stressors encountered in everyday living.

In regard to the psychogenic attitudes, psychosomatic correlates, and prognostic indices scales of the MBHI, a mainly consistent pattern of emotional-focused coping strategies was revealed. Since these scales reflect transient aspects of current levels of emotional discomfort, it was anticipated that the emotional-focused pattern would correspond with the MCMI, Axis I scales. In general, this emotional-regulating pattern of coping appears to support observations noted in the stress management study by Martelli, Auerbach, Alexander, and Mercuri (1987). In the process of coping with dental surgery stress, emotional-focused coping appeared beneficial at the early treatment stage, whereas problem-solving strategies appeared beneficial in long-term treatment outcome. In terms of the alcoholics, it appears logical that as emotional-discomfort subsides, and alcohol consumption patterns are not reinstated, treatment programs may provide an opportunity to learn how to generalize resources or to acquire new coping skills. Flexible coping strategies would likely be evident over a reasonable period of time. Subsequent to this assumption, positive treatment outcome would likely be related to multiple assessments over time, rather than directing efforts to sub-type the alcoholic.

Alcoholic Prototypes

In the current study, attempts to sub-type the alcoholic group, using the MCMI, Axis II, yelded a level of concurrence with previous research findings, yet in doing so provided no notable, clinically-significant information. The prototypes derived include the following: avoidant, dependent, narcissistic, passive-aggressive, schizotypal, and borderline. The narcissistic prototype was waived from further analysis due to the small representation. In comparison with the Nervanio and Gross (1983) and the Bartsch and Hoffman (1985) research findings, the prototypes emerging in the current study tend to be similarly represented as follows: (a) avoidant and dependent as mixed character dysphoria; (b) passive-aggressive as passive-aggressive; and (c) schizotypal and borderline as severe distress. Missing from the prototypes identified by Nervanio and Gross (1983) were the following: sociopathic, antisocial, acute reactive depression or classic alcoholic. Similarly, the prototypes notably absent from the Bartsch ahd Hoffman (1985) classification were: classic alcoholic, psychopathic, and psychotic. As previously anticipated, not all pure types were identified due to the nature of the sample within the current study. That is, the alcohol-abusing subjects were typically middle-class, psychiatric-referrals who were hospitalized in community settings.

Appraised coping strategies, as they related to identified protoyptes revealed a consistent pattern of emotional-focused coping in context of social stress. In addition, it was noted that borderline, avoidant, and passive-aggressive prototypes were more inclined to use emotional-regulating strategies than were schizotypal and dependent prototypes.

Summary

The overall results pertaining to the first hypothesis indicated that different personality styles tend to be related to different coping strategies. In terms of clinical significance, individual resources were identified and translated in terms of treatment recommendations. Categorizing the alcoholic group into prototypes identified in previous research studies essentially provided no additional clinically-relevant information. Moreover, the MCMI provided more relevant clinical information than did the MBHI which is intended for use amongst a non-psychiatric population.

Hypothesis 2 Discussion

The results of the second hypothesis did not support a relationship between coping strategies and level of social support. Level of social support tended in turn to be related to the following: affirmation of a confidant, marital status, parental support through modeling of problem-solving skills and

age level. That is, the alcoholics tended to perceive more social support if they had a confidant, were married, had parents who demonstrated use of problem-solving strategies in response to stressful events, and if they were older in age. These social variables may be influential to treatment outcome as Pattison and Kaufman (1982) suggest. However, they did not tend to be associated with appraised coping strategies identified in the current study.

Hypothesis 3 Discussion

The third hypothesis which proposed a relationship between coping strategies and career satisfaction was not supported by the results. Career satisfaction tended to be related to level of social support. Again, a social network which is perceived as supportive may provide one course for emotional-regulating coping. In addition, age level, rather than career satisfaction, revealed a relationship with coping strategies. That is, younger individuals tended to use more emotional-focused coping strategies in resolving a work stressor. This may suggest that older individuals perhaps have acquired more experience and confidence in terms of problem-solving resources to cope with work-related stressors.

Hypothesis 4 Discussion

The results of the hypothesis which contained the prediction that the coping strategies of the alcoholics would differ from

the non-alcoholics in terms of frequency and problem-solving efforts was supported by the results. The alcoholics emerged as oriented towards an emotional-focused bias across all three categories of stressors. Additionally, in terms of a composite score comprised of all three stress events, they in fact differed from their non-alcoholic counterparts, both in terms of emotional-focused strategies and also in terms of their problem-solving strategies.

That is, overall the alcoholics tended to generate more coping efforts than the non-alcoholics in both strategy categories. However, quantity does not equate with quality and issues of selectivity and levels of efficiency are not addressed in the current study. The results of the current investigation confirm the Donovan and Chaney (1985) postulation that alcoholics in general tend to be inflexible and frequently demonstrate deficits in social and communication skills. The results also reveal some resource deficits as well as substantial individual differences. The interpersonal differences are considerable if subtle personality distinctions are considered. Furthermore, the results provide limited support for the concept of a common failure identity (Yost & Mines, 1985) or pervasive low self-esteem (Carroll, 1982), which is often used to explain maladaptive coping tendencies. Often again, this practices serves to label in a general sense, and does little to enhance clinically important distinctions typically essential in a

practical setting. To label, in a simplistic sense, provides a reason for maladaptive tendencies or an excuse for their maintenance (Wilson, 1987). In addition, lacking appreciation for subtle differences or misconstruing transient with stable dimensions, a label can readily become a self-fulfilling prophesy or base for stigmatization by others. To conclude, the overall results tend to support Millon's (1986) model of personality. Relatively stable (versus transient) personality dimensions were distinctively related to appraised coping strategies and degrees of normality or resources as well as degrees of psychopathology were readily identifiable and easily translatable to practical treatment recommendations.

Characteristics of the male subjects

Social and demographic variables distinguishing the alcoholics from the non-alcoholics included the following: level of physical health, education level, marital status, level of social support, recent major stressor, degree of stress difficulty, and alcohol abuse tendencies as measured by the SMAST.

While it may be argued that the factors listed above, contribute to alcohol abuse tendencies and indirectly confound coping strategy relationships with personality dimensions, so may it be proposed that other social factors may offset the effects of the variables that suggest deficits or vulnerabilities. For example, age, occupation, career satisfaction, confidant

availability, parental support and father's drinking tendencies, were all variables in which the alcoholics did not appear unlike the non-alcoholics. In addition, social variables showing a modest relationship with coping strategies were: age, physical health, and confidant availability. Clearly, personal perceptions regarding coping tend to be influential in drinking (Donovan & Marlatte, 1980; Glantz, 1987; Sanchez-Craig, 1976; Wills & Shiffman, 1985) and these cognitions are directly related to stable aspects (or structures) of the personality (Millon, 1986). Social variables representing subject characteristics provided a somewhat minor level of influence in the assessment of coping strategies while personality dimensions were identified as a substantial influence, especially in regards to relevant clinical information.

Limitations and Implications

Practical considerations of economic constraints were considered in undertaking this study. Individuals excluded from this study included psychotics, females, and individuals under twenty years of age. Patients were approached approximately one week after admission to hospital. A longer duration after admission may in some cases be advisable to rule out potentially-confounding physiological influences. Two hospitals in the Edmonton area were found to have similar SES males with a history of alcoholism. Additional community hospitals located elsewhere in Alberta may have provided different SES profiles.

Nonalcoholic males recruited as volunteers from community resources were also found to be representative. However, caution should be exercised in interpreting the contrast of community volunteers. Hospitalized, non-alcoholic men might have provided somewhat different profiles due to current levels of stress experience in their lives. Review of the literature focused on personality and coping research pertinent to this study. Instruments selected for use included questionnaires that the individual alcoholic could readily complete, with no validation sought through a significant other. Behavioral nor physiological indices are not included in this investigation. The study was essentially correlational in nature with no causality assumed and generalizability tends to be restricted to community hospitals providing short-term psychiatric intervention.

The objectives of this study are warranted considering the need to enhance our understanding of the alcoholic patient. Since a substantial amount of former research has been directed toward classifying alcoholics within narrow categories of pathological characteristics, the study represented an attempt to include broader dimensions of the individual within an adaptational perspective. That is, the potential resources as well as coping strategies which the individual was underutilizing were examined. It is these latter facets which yield clinically meaningful implications.

Future Research Direction

Research should be undertaken amongst other hospitalized patients, substance-abusers and alcoholics institutionalized in alternative treatment facilities using the WCCL in conjunction with personality measures. The WCCL might also be included with physiological measures, neuropsychological and intellectual assessments to explore alternative interpretations influential in the coping process. Case studies and longitudinal studies would also tend to enhance validity with the WCCL. The results of the study imply that treatment programs would benefit by inclusion of additional clinical data such as provided in the WCCL. In addition, use of the WCCL as a repeated measure during the process of a program may provide another area of future study.

Clinical Considerations

The results of the current study suggest that alcoholics are not all the same in terms of personality, self-esteem, appraised coping strategies or social attributes. Inclusion of coping strategies at the individual level helps to identify resources that may be addressed in counselling. Not one alcoholic refused to participate in the current study and many expressed interest in the outcome. That is, many alcoholics wanted to know what resources could be identified. This interest on the part of the alcoholics suggests an opportunity to interrupt current levels of information processing. The feedback on coping resources may be interpreted as one way to gain attention and perhaps a level of motivation by imparting new information and conceivably, hope.

It is a potential beginning in building rapport with a population of clients frequently perceived as challenging. In addition, it also provides useful reference in counselling because it pertains directly to the appraised resources and vulnerabilities of the individual. Ultimately, it is hoped that by increasing our understanding of the alcoholic client, assessments, treatment recommendations, and program development will be enhanced. It appears reasonable to assume that efficient intervention may serve to reduce the human and monetary tolls currently incurred through repeated admissions to the community hospitals.

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Appendix A

Questionnaire

PERSONALITY STYLES AND COPING STRATEGIES

Investigators:

Dr. E. E. Fox, Department of Educational Psychology,

L. M. Griffiths, M. Ed., Certified Psychologist

Dr. E. E. Fox and I are investigating the relationship between personality styles and appraised coping strategies. We are trying to gather current information on how men typically manage stress encountered in daily living as well as the various resources which they may be able to identify. The enclosed questionnaires will be identified by a number, and the contents are to be used in a Ph.D. thesis. Should information from this investigation be published, your identity will remain anonymous. I fully understand that the study is voluntary and that the researcher will answer any questions which I may have in this regard.

Signature of participant _____

Date _____

Signature of witness _____

In this section, we would like to know a little about your background. The first two questions require your age and occupation (or what you previously worked at if currently unemployed). The remaining questions require you to circle the appropriate response. Please answer all questions and remember that all information is confidential. Thank you.

1. Age: _____ years.

2. What is your occupation (if unemployed, previous positions held)? _____

3. Quality of job or career satisfaction?
   Excellent ____ Good ____ Fair ____ Poor ____

4. Do you have a friend or relative that you feel you can really count on and tell your troubles to?
   Yes _____ No _____

5. Quality of the relationship?
   Excellent ____ Good ____ Fair ____ Poor ____

6. As a child, how did you get along with your father?
   Excellent ____ Good ____ Fair ____ Poor ____

7. Did your father drink alcohol?
   Not at all ____ Just socially ____ Heavily ____
   Likely alcoholic ____

8. Did your parent(s) set good examples of how to solve problems in life?
   Most of the time ____ Frequently ____ Seldom ____
   Never ____

9. What is your level of education?
   Post secondary education ____ Grade 12 or equivalent ____
   Less than a Grade 12 equivalent ____

10. Marital Status:
    Married ____ Single ____ Separated ____ Divorced ____

11. Quality of the relationship?
Excellent ____ Good ____ Fair ____ Poor ____

12. Have you recently experienced a major stressor in your life such as a death, divorce, loss of employment, or loss of a friend? Yes ____ No ____

13. How difficult was this loss for you? Mildly difficult ____
Moderately difficult ____ Extremely difficult ____

14. At what level would you rate your current physical health?
Excellent ____ Good ____ Fair ____ Poor ____

Questionnaire: Order of presentation:

1. Social/Demographics.

2. Short Michigan Alcoholism Screening Test (Selzer, Vinokir, & Van-Rooijen, 1975).

3. Millon Clinical Multiaxial Inventory (Millon, 1983).

4. Ways of Coping Checklist (Lazarus & Folkman, 1984).

5. Millon Behavioral Health Inventory (Millon, Green, Meagher, 1982).